DOCTORAL THESIS

An exploration of anxiety and depression among adolescents and adults in Bulgaria

Tsocheva, Ivelina

Award date:
2015

Awarding institution:
University of Roehampton

AN EXPLORATION OF ANXIETY AND DEPRESSION AMONG ADOLESCENTS AND ADULTS IN BULGARIA

By

Ivelina Tsocheva, BSc, PGDip Psychology

Thesis submitted in partial fulfilment of the requirements for the degree of PhD

Department of Psychology

University of Roehampton

2015

ABSTRACT

Anxiety and depression are among the most prevalent psychological disorders affecting a large number of people across different cultures. At present, these conditions have not been examined among the general population of Bulgaria. This thesis is a large-scale project involving Bulgarian adolescents aged 13-17 and Bulgarian adults aged 35-58. The main aims are:

1/ to investigate the prevalence and correlates of anxiety and depression in Bulgarian adolescents and adults because this population has been under-researched on these topics

2/ to assess mental health literacy about depression in these two groups. Research indicates that mental health literacy rates vary in adolescents and adults across countries and cultures and are influences by a number of factors such as: healthcare system, social attitudes and expectations, education and social support.

3/ to study the personal experience of anxiety through qualitative methods. The purpose of this analysis is to get the individual point of view. A significant overlap in symptoms exist between depression and anxiety but anxiety has many different forms and aspects (panic attacks, social phobia, generalised anxiety disorder, etc.) that are worthy of qualitative investigation.

The two age groups were chosen because:

A) their life experiences were very different from a cultural point of view: the adolescents grew in a global, modern and democratic Bulgaria and the adults used to live under the isolation and restrictions of the Communist rule.

B) adolescence and adulthood are two distinctive life stages characterised by: social/ emotional changes, changes in health attitudes/behaviour and transition between concrete/ abstract thinking.

Three studies were carried out in Bulgaria: Study 1 and Study 2 were quantitative, cross-sectional and Study 3 was qualitative. For Study 1 and Study 2 adolescents (n=700) were randomly recruited from public schools and adults (n=250) were recruited from employment companies. Study 3 applied interpretative phenomenological analysis to unstructured interviews conducted with adolescents (n=10) and adults (n=10) recruited from a sub-sample of Study 1.

Results from Study 1 suggested that adolescents and adults had marked differences in specific sub-types of anxiety with adults scoring higher on social phobia, physical injury anxiety and panic agoraphobia. Anxiety and depression correlated strongly in adults. Significant gender differences were observed with females having higher prevalence rates of anxiety and depression in both age groups. Adults also scored higher on interdependency, indicating a collectivist mind set associated with Communism.

Results from Study 2 indicated that both age groups had low levels of mental health literacy. However, adults appeared to be more affected by stigma associated with psychological illnesses.

Qualitative results from Study 3 highlighted personal experiences and identified additional risk factors associated with onset and persistence of anxiety. Some of these factors were prevalent across both age groups and others were age specific.

Further research work needs to focus on identifying helpful strategies in prevention, diagnosis and treatment of these conditions in adolescents and adults.

Improving health education across different age groups and reducing stigma towards psychological illness are of particular importance.

TABLE OF CONTENTS

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

I would like to thank the Department of Psychology at the University of Roehampton for the unique opportunity to write this thesis. It has been a wonderful and rewarding learning experience.

I am very grateful to my PhD supervisors Professor Cecilia Essau and Dr Georgiou for their continuous encouragement and support over the last five years. Their knowledge, patience, wisdom and useful suggestions have helped me to keep going until completion. I could not have asked for more understanding and helpful supervisors.

I would also like to express my gratitude to the warm-hearted people from my home town Veliko Tarnovo in Bulgaria who have helped me with the long and difficult data collection process and to the participants who have kindly agreed to take part in this project.

Special thanks to my beloved partner Dinko for his unconditional love and support, for helping me to survive the stress and not letting me give up. None of this would have been possible without you!

PUBLICATIONS AND CONFERENCE PAPERS

1) Tsocheva, I., Sasagawa, S., Georgiou, G. and Essau, C. (2013) Psychometric Properties of the Bulgarian Translation of the Spence Children's Anxiety Scale. *Journal of Psychological Abnormalities in Children* 1:101. doi: 10.4172/2329-9525.1000101

2) Tsocheva, I., Ozer, B. and Essau, C. (under review) A confirmatory factor analysis study of Centre for Epidemiological Studies Depression Scale for Adolescents in Bulgaria, *Journal of Advanced Nursing,* JOA13-165R1

3) Tsocheva, I. (2011, July) An exploration of anxiety across different generations in Eastern Europe (Bulgaria). Paper presented at the 6th International Conference on Child and Adolescent Psychopathology (11-12 July, 2011), London, UK

4) Tsocheva, I, Sasagawa, S., Georgiou, G. and Essau, C. (2012, July) Anxiety symptoms among children and adolescents in Bulgaria. Paper presented at the

7th International Conference on Child and Adolescent Psychopathology (16-18 July, 2012), London, UK

5) Tsocheva, I. (2014, July) Mental Health Literacy in Bulgarian adolescents: Knowledge and beliefs about recognition and treatment of Depression. Paper presented at the 9th International Conference on Child and Adolescent Psychopathology (14-16 July, 2014), London, UK

Dedication

I dedicate this work to my wonderful and precious daughter Adria.

Thank you for coming into my life and making me a better person.

CHAPTER 1: INTRODUCTION

1. Background and context of the thesis

Adolescence and adulthood are two distinctive stages of our life-course. Adolescence is a transitional period between puberty and legal adulthood and adulthood is a stage of biological and social maturity. In order to understand the individuals better from a psychological point of view, both stages need to be

examined to establish mental health history, age of onset for certain disorders, causality and risk factors.

Coleman and Hendry (1999) viewed adolescence as a preparation for adulthood, a period of many transitions between different social situations. The most important step from concrete to abstract thinking and reasoning is also taken during adolescence.

Classical psychologists such as Erikson and Anna Freud focused on the psychological confusion and the turbulent nature of adolescence. (Lerner and Steinberg, 2004). New emotional experiences, feelings and role rehearsing during adolescence put a lot of pressure on young people and may cause difficulties. Adolescents are usually easily influenced by their social surroundings and very vulnerable thus many psychological disorders, including anxiety and depression have their first onset during this period. Kessler et al. (2007) conducted a large cross-cultural study employing over 85 000 participants across Africa, Asia, the Americas, Europe, and the Middle East. They studied lifetime prevalence, projected lifetime risk, and age of onset of DSM-IV disorders. Results indicated that age of onset is very early for some anxiety disorders (7-14 years) and significantly later for other anxiety disorders (24-50). Lifetime prevalence estimates were: anxiety disorders 4.8-31.0% and for mood disorders 3.3-21.4%.

In addition, research studies among adults also demonstrated that anxiety and depressive disorders run a chronic course into adulthood. Pollack et al. (1996) investigated the correlates of a childhood history of anxiety disorders in 194 adult patients. They examined the presence of a childhood anxiety disorder and studied its association with comorbid anxiety and depressive disorders. Over half of the patients had a childhood history anxiety disorders. This group had higher rates of

comorbid anxiety and depression. This is supported by Klein et al. (2013) who conducted a longitudinal study of depression with 816 participants over four developmental periods: Childhood, Adolescence, Emerging Adulthood and Adulthood. They studied the recurrence and comorbidity of Major Depressive Disorder and found out it was lower in childhood compared to subsequent periods, and higher in Emerging Adulthood than Adulthood. Female gender predicted first incident MDD in all four periods but was not associated with recurrence. Comorbidity rates were comparable across periods.

Essau et al. (2014) found that adolescent anxiety is a predictor for poor social adjustment, family problems and substance abuse in adulthood. People who have experienced anxiety disorders in adolescence, had a higher risk of poor psychosocial outcome during adulthood compared to people who had the onset of their anxiety disorders at childhood. Problems included poor adjustment at work, family problems, poor coping skills and less overall life satisfaction. Adolescent anxiety was also associated with anxiety in adulthood (Essau, et al., 2014).

Weissman (1990) argued that adults with some types of anxiety disorders were at an increased risk for social impairment, not getting along with and not being able to confide in their partners or achieve financial independence. Thus, the impairment associated with anxiety in adolescents has a long-term implication for adult functioning.

Research shows that anxiety and depression differ by gender. Faravelli (2013) studied the lifetime incidence of depressive and anxiety disorders by age and gender in a community sample. They examined 2363 participants and concluded that lifetime prevalence of affective disorders resulted higher in females.

Anxiety and depression have common correlates with other factors such as social support (the perception and actual levels of support from significant others in the individuals' lives) and self-construals (a self-definition devised by Markus and Kutayama, 1991, putting the individual independently of others or interdependently with them). It would be incomplete to discuss anxiety and depression without the social and individual context. Cross and Madson (1997) argued that men construct and maintain an independent self-construal and women construct and maintain an interdependent self-construal. The authors considered self-construals to be responsible for many gender differences in psychological states and social behaviour.

Studies like these highlight the importance of identifying symptoms and risk factors as early as possible. The timely diagnosis and appropriate treatment of anxiety and depressive disorders are affected by a number of factors: priorities in healthcare in different world countries and treatment availability (Desjarlais et al, 1995), cultural differences (Essau and Petermann, 2001), social support (Schwarzer and Knoll , 2003), mental health literacy (Jorm, 2000) and stigma associated with help-seeking for mental disorders (Corrigan, 2004, Ben Porath, 2002).

Research studies exploring these factors have been conducted mainly in western industrialised countries. This is due to various issues, many of them related to access, funding, established research traditions, etc, but this creates a biased and incomplete picture as the cultural values in these countries are quite similar.

The current thesis' purpose is to address this gap in knowledge by examining the prevalence and correlates of anxiety and depression and the underlying factors across two groups in Bulgaria – adolescents and adult group. The contributions

are expected to be threefold. Firstly, to our knowledge, anxiety and depression have not been explored in adolescents or adults in Bulgaria. Despite the country's status as an EU member since 2007, psychological research in this area has been negligible. Secondly, the healthcare system and practices in the region have been following obsolete beliefs about treatment and prevention that are different to those of established democracies. (Townsend et al., 2004). As a result of these factors, mental health literacy about psychological conditions has never been considered an important issue before and also has never been researched in adolescents and adults in Bulgaria. Thirdly, the study will complete the adolescent-adult comparison by collecting and analysing qualitative data about personal anxiety. It is expected to give an in-depth account of two dramatically different experiences of adolescent/ subsequently adult anxiety due to the different social climates in Communism (for the adults) and in democracy (for the adolescents).

1.2. Objectives of the Thesis

The main purpose of this thesis is to study anxiety and depression in a general population sample of adolescents and adults in Bulgaria. Specific aims of the project are to examine:

1. Prevalence rates of anxiety and depression in adolescents and adults
2. The correlates of anxiety and depression and the extent to which they differ across these two groups. The examined correlates were; gender, age, social support and self-construals
3. Mental health literacy about depression in adolescents and adults
4. Personal experiences of anxiety in both groups

This will be done in three separate studies: Study 1 (Chapter 3) , Study 2 (Chapter 4) and Study 3 (Chapter 5).

1.3. Bulgarian cultural context and modern history of mental healthcare

Culture is a complex concept comprising social behaviour, ideas, custom and lifestyle of particular people in a society. According to Deal and Kennedy (1982) it is the integrated pattern of human behaviour that includes thought, speech, action, and artefacts and depends on man's capacity for learning and transmitting knowledge to succeeding generations.

Each country has different cultural activities, rituals and values. However, The Communist Bloc in 20th century created an interesting phenomenon – a large number of countries following similar ideology and sharing a cultural structure introduced and enforced by the state for a number of generations. In Eastern Europe this so-called bloc culture meant that particular norms and rules were followed and moral values were shared in a deliberately created state of isolation. This severely impacted all aspects of life in communist countries. During the communist regime in Bulgaria (1944 – 1989) the Soviet 'Semashko' health care model was adopted. Borissov and Rathwell (1996) argued that healthcare was free and accessible, but at the same time centrally controlled and non-flexible. Shortages in healthcare were not registered officially but became apparent with the economic decline. With the fall of Communism in 1989, many of the components of this model were exposed as unreliable in Bulgaria.

The prosperity myth about the Communist bloc was dispersed with the arrival of democracy in the Eastern bloc countries. Many long-lasting problems were identified and a major public health crisis began. According to Cornia and

Paniccia (2000) this was a direct result of the prevalent over-reliance on the state for guidance in the process of transformation. The changes brought the accumulation of a large amount of psychosocial stress created by years of isolation and detachment and the inability to cope with the overwhelming nature of healthcare reformation.

Townsend et al. (2004) stated that after 1989 most of the mental health systems in the region have been operating outmoded facilities and following outdated beliefs about treatment, therapy and prevention. There is almost no research into mental health services in the region, a result of a difficult transition which saw mental disorders being ignored for years without appropriate diagnosis or adequate treatment.

Previously mental well-being was not discussed in the region and mental disorders were viewed only as severe illnesses requiring institutionalisation. Sufferers were put out of public sight. Gater et al. (2005) acknowledged that at present people are becoming more aware of the importance of mental health issues due to the surge in rates of addictions, crime and violence. During the long transition process people have become disillusioned and confused and experience emotional distress and social impairment. Bauer and Zimmerman (1999) even argued that these are the reasons for emigration among young people from Eastern Europe.

In these circumstances, many develop disorders of sub-threshold or clinical severity or have previous conditions aggravated.

At present Bulgaria is the poorest country in the European Union – the wages and living standards are predominantly low and life expectancy is shorter than the rest of EU. Chavdarova (2001) noted that nstitutions are mostly ineffective and

corruption is commonplace. Corruption in Bulgaria is widespread at all government levels and public life areas. The most important fields are: public administration (central, regional, local), parliament, political structures, police and especially the judiciary, the military, public services and utilities, education and the non-government sector In addition, Bulgarians were also ranked 144th out of 156 countries in the World Happiness Index (UN World Happiness Report, 2013), and according to Gallup poll "the main reasons for gloom in Bulgaria are the ubiquitous corruption and a lack of the freedom to make choices, which is even more limited than it is in Botswana, the country just below Bulgaria in the rankings."

All of these create a feeling of hopelessness, fear, stress and uncertainty, especially in young people and stressful events are directly related to anxiety (Maes et al, 1998) and depression (Hammen, 2005, Dahlin, 2005). These are prerequisites for high prevalence of anxiety and depression symptoms among Bulgarians.

1.4. Overview of anxiety and anxiety disorders

“Anxiety is a multisystem response to a perceived threat or danger. It reflects a combination of biochemical changes in the body, the patient's personal history and memory, and the social situation” according to Gale Encyclopaedia of Medicine (2008). Anxiety, as a mood condition is associated with negative emotions, expressed through physical, cognitive and behavioural response systems. People experience anxiety at some times in their life as a natural reaction to circumstances – work pressure, exams, etc. Normal anxiety can help us perform better in certain situations. However, in some cases, anxiety can occur without the

presence of any trigger stimulus and can cause constant feelings of discomfort, worry and fear. Anxiety is “a state of intense apprehension, uncertainty, and fear resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted.” (The American Heritage Medical Dictionary, 2007). A high level of anxiety can ruin lives, force people to stay indoors and out of social situations – in these situations we are talking about clinical anxiety or anxiety disorders (such as generalised anxiety disorder, social anxiety disorder (also called social phobia), panic disorders, phobias and obsessive-compulsive disorder). Here are some brief descriptions of the conditions and the diagnostic criteria.

- Generalised anxiety disorder is characterised by excessive worry about a number of different domains or activities (family, health, work problems, money worries). The symptoms are difficult to control and include poor concentration, tiredness, irritability, restlessness and problems with sleeping. The worry must not be exclusively focused on the symptoms of another disorder and must not occur as a part of another mood disorder, psychotic disorder, or developmental disorder. The anxiety must lead to significant distress or functional impairment. (Borkovec, 1994)
- Social anxiety disorder (social phobia) is an excessive fear of social or performance situations. Individuals with social phobia avoid social gatherings, meetings and conversations. It is a fear of negative evaluation and embarrassing oneself in front of others. It should be noted that the anxiety in social phobia must not be focused on the symptoms of another health condition. A patient with facial disfigurement might avoid meeting people for fear of having his condition noticed by other people) but this would not be diagnosed as social phobia. To meet the

criteria the fear of social situations must lead to significant functional impairment or distress (Veale, 2003).

- Panic disorder with and without agoraphobia

  Panic disorder is the prolonged experiencing of unexpected panic attacks (an overwhelming feeling of severe anxiety, accompanied by feeling breathless and dizzy) and occurring without the presence of a trigger stimulus. In addition it also comprises concern about having another attack, anxiety about their consequences and behavioural change as a result of these attacks. Agoraphobia is anxiety about being in places or situations from which escape might be difficult (or embarrassing) or where help may not be available in the event of a sudden panic attack. Examples of these situations include being in a crowd, shopping, traveling in a motor vehicle or standing in a queue. Such situations are avoided by the individual so they become withdrawn. (Mehta, 2003)

- Phobia is the excessive or unreasonable fear of an object or situation (flying, animals, heights, blood), combined with avoidance of the feared object. The fear must not be associated with other medical conditions and must lead to profound distress and impairment. Childhood phobias are common such as excessive fear of animals, water, thunderstorms, darkness, and medical or dental procedures. The most common objects feared by people are spiders, mice, snakes, and heights (Bourdon et al., 1988).

- Obsessive-compulsive disorder (OCD) is identified by the presence of obsessions (recurrent and intrusive thoughts, urges or images that cause severe anxiety) and/or compulsions (repetitive behaviours or mental acts performed by individuals to reduce the anxiety generated by obsessions). Common obsessions include fear of contamination or disturbing sexual thoughts whereas typical compulsions might include washing, putting things in certain order and repetitive

checking. The obsessions and compulsions must be distressing, impairing and time-consuming to be classified as with OCD. OCD affects all cultures and ethnic groups and, unlike other anxiety disorders, males and females are equally affected by it. (Rasmussen and Eisen, 1992).

1.5. Overview of Depression

Depression is often dismissed as the very usual ”feeling down” – a temporary expression of sadness people experience every now and then. Depression however, is a serious illness and it affects every part of a person’s life. According to DSM-V criteria depression is an “irrational worry, preoccupation with unpleasant worries, trouble relaxing, feeling tense, fear that something awful might happen.” “People with depressed mood can feel sad, anxious, empty, hopeless, helpless, worthless, guilty, irritable, ashamed or restless. They may lose interest in activities that were once pleasurable, experience loss of appetite or overeating, have problems concentrating, remembering details or making decisions, and may contemplate, attempt or commit suicide. Insomnia, excessive sleeping, fatigue, aches, pains, digestive problems or reduced energy may also be present.” (NIMH, 2014). Symptoms are both physical and psychological and encompass not only everyday occurrences such as work, studying, sleeping and eating patterns, but also deeper emotional aspects – the way one interacts with others and how he/she views oneself as a person. Thus the crucial need for the right depression treatment – without it a person will suffer the negative consequences for lengthy periods of time. Beck and Worthen (1972) have identified a wide range of potential causes for depression – from personality traits and life events through to medical illnesses and substance abuse. More recently, Zwolinski (2014) viewed depression as caused by external events, financial worries, debt and world problems. Wilkinson et al. (1997) argued that in certain

countries where income inequalities, lower socio-economical class, dangerous environments and deprivation are prevalent, the psychosocial stress leads to deterioration in mental health. Bulgaria, where the current study took place, is characterised at present by social instability, poverty and severe economical problems – risk conditions for elevated levels of anxiety and depression.

CHAPTER 2: METHODOLOGY

2.1. Overview

In this chapter the employed methodology will be outlined. There will be a summary about used research methodology and details about participants, measure, data collection and analyses.

2.2. Research methodology

For this thesis a combination of quantitative and qualitative methods was used (the so-called mixer-method approach). Newman andBenz (1998) argued that the two approaches can be viewed as compatible rather than contrasting because they are “interactive places on a methodological and philosophical continuum” (p.11). Chronologically, in this project the qualitative part of the research took place after the quantitative, giving me the opportunity to add new dimensions to my quantitative findings and to study the subject in great detail.

In order to achieve an effective combination of methods for this thesis, their main characteristics were considered and the advantages and disadvantages of both methods were evaluated.

According to Given (2008) quantitative research investigates observable factors with the help of statistical techniques and mathematical models. The data is collected (in this case with the help of survey questionnaires) and presented

numerically in the shape of percentages. The main advantage of quantitative research is that it allows data from a large number of participants to be analysed quickly. It gives the researcher the opportunity to establish causal relationships by manipulating factors thought to influence the investigated phenomenon while controlling other variables relevant to the experimental outcomes. Sale et al. (2002) stated that the quantitative paradigm was based on positivism and acknowledged an objective reality (truth) that exited independently of our perception of it. In such reality the investigator studies the phenomenon but cannot influence it, the researcher and the participants in the research are separate entities. At the same time, not all phenomena can be quantified and this is the main disadvantage of quantitative research. Mujis (2010) argues that the usefulness of quantitative methods is limited when it comes to measuring categories such as individual attitudes and beliefs. Developing research questions can lead to structural bias where the data actually reflects the view of them instead of the participating subject. Quantitative results are limited as they are less elaborate accounts of human perception. The control, exercised by the researcher creates an artificial environment that is different to the real world. Thus, the results obtained quantitatively do not provide a very accurate description of what people feel about certain subject (Currall et al.,1999).

Qualitative research, on the other hand, gives researchers the opportunity to get an in-depth account of the examined topic by considering the individual factor. Bogdan and Taylor (1990) argued that qualitative understanding comes from exploring the totality of the situation by encompassing factors that cannot be measured quantitatively. It is open, because it allows for new topic areas to emerge and can give a better insight into people's behaviour. Neuman and Robson (2004) stated that qualitative studies do provide quality and texture to the research

but the time consuming methods mean that much fewer people can take part and the results cannot be generalizable. Subjective accounts do not always allow for effective comparisons as there might be a huge variety of answers. The end product of qualitative research is a combination of researcher and participant's efforts. It is subjective and cannot be replicated.

Because this project follows a mixed method design, an outline of mixed methods typology is necessary. Creswell and Plano Clark (2007) identified four types of mixed-methods designs:

1. Triangulation design – where data is collected simultaneously
2. Embedded design – one research design is embedded within a design planned by the other type.
3. Explanatory design - qualitative data builds upon quantitative results
4. Exploratory design, where qualitative data is collected first followed by quantitative data.

According to this classification, my thesis will follow an explanatory design. Quantitative data is collected first, followed by a qualitative study seeking to expand our knowledge by explaining the statistical results in a different light.

The figure below illustrates the research methodology employed for each of the three studies.

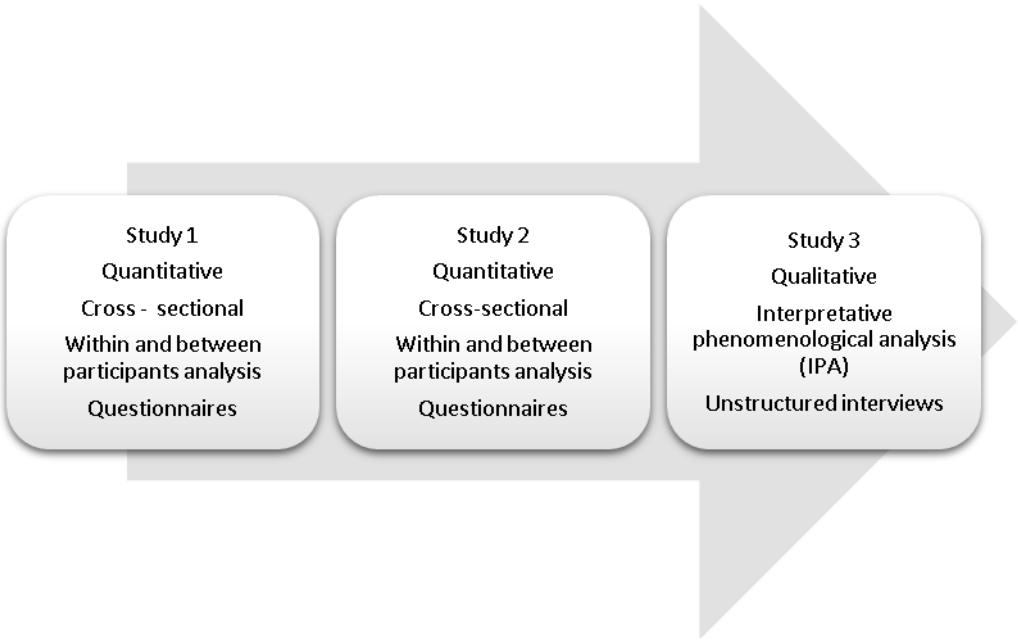


Figure 2.1. Outline of research methodology.

Based on this outline, the Two Quantitative studies collect data from a large number of participants. Study 1 and Study 2 were conducted and analysed simultaneously in order to establish prevalence, correlates of anxiety and depression and mental health literacy rates. Study 3 added to the results obtained in Study 1 and Study 2, by examining in-depth interviews with a small number of participants through Interpretative Phenomenological analysis.

2.3. Participants

700 adolescents and 250 adults took part in Study 1 and Study 2. They were recruited from community settings. The purpose was to obtain representative results for the two groups and to compare their results.

Study 3 recruited 10 adolescents and 10 adults from a sub-sample of Study 1. It gave me the opportunity to examine the subject individually from the participants' personal perspective.

2.4. Measures:

2.4.1. Quantitative measures

Table 2.1. Measures for adolescents

Name of Measure	Constructs to be measured
Spence Child Anxiety Scale (Spence, 1998)	Measures anxiety symptoms in children and adolescents
Self-Construal Scale (Singelis, 1994)	Measures respondents' beliefs about the relationship between the self and others
Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997)	Assesses general difficulties and positive attributes
Social Support Scale	Measures perceived support available to the participants
Center for Epidemiological Studies Depression Scale for Children (CES-DC)	Measures depression indicators
Demographics	Age, gender, ethnicity, religion

Table 2.2. Measures for Adults

Name of	Constructs to be measured

Measures	
Spence-Essau Anxiety Scale (Spence and Essau, 2008)	Measures anxiety symptoms in adults
Self-Construal Scale (Singelis, 1994)	Measures respondents' beliefs about the relationship between the self and others
Depression, Anxiety, and Stress Scale (Lovibond and Lovibond, 1995)	Assesses current symptoms of depression, anxiety and stress
Social Support Scale	Measures perceived support available to the participants
Demographics	Age, gender, ethnicity, religion, education

A specimen of the Measures used for Adolescents can be found in Appendix XIII. A specimen of their Bulgarian translation can be found in Appendix XV.

In order to measure anxiety symptoms, Spence Children Anxiety Scale (SCAS) was adopted for this study. It has 45 items, and the respondent can answer each one of them with the words: never, sometimes, often and always. Spence Children Anxiety Scale is a scale used to evaluate symptoms relating to separation anxiety, social phobia, obsessive-compulsive disorder, panic-agoraphobia, generalized anxiety, and fears of physical injury. SCAS was tested in a number of international studies and was found to be a reliable and valid screening instrument. Spence-Essau (2008) devised an adult version of the scale which also showed high internal consistency and was used for the adult group of this study. Below is a table summary of some studies that employed SCAS and were carried out in order to measure children and adolescents' anxiety symptoms in different parts of the world.

Table 2.3. SCAS international results

Source (year)	**Country of study**	**Sample Size**	**Range (Age)**	**Mean (SD) SCAS**
Muris et al. (2000)	Netherlands	1,011	7– 19	18.11 (12.9)
Spence et al. (2003)	Australia	875	13 – 14	21.72 (13.5)

Essau et al. (2008) Study 1	China	428	12 – 17	29.21 (15.5)
Whiteside and Brown (2008)	USA	85	9 - 18	17.68 (11.9)
Crane Amaya and Campbell (2010)	Australia and Colombia	516	8-12	19.00 (13.9) 36.68 (16.7)
Essau et al. (2011a)	Cyprus	1,072	12 – 17	28.62 (14.8)
Orgilés et al. (2013)	Spain	1,374	13 – 17	25.26 (12.5)
Tsocheva et al. (2015)	Bulgaria	700	13 – 17	???

The Depression, Anxiety, and Stress Scale (Lovibond and Lovibond, 1995) also known as DASS-21 was used to measure depression, anxiety and stress. It

contains 21 items with a rating scale from 0 to 3 where 0 means "did not apply to me" and 3 means "applied to me very much". DASS has shown excellent psychometric properties in clinical (Antony et al.1998; Brown et al. 1997) and non-clinical samples (Clara et.al 2001; Lovibond and Lovibond, 1995) and has been translated and utilised in more than 30 languages. Akinand Cetin(2007) have used the scale in Turkey and their results demonstrated that the DASS is a valid and reliable instrument. Crawford and Henry (2003) have administered the scale to a large non-clinical sample of British adults and their results show that the reliability of the DASS was excellent, and the measure had good validity conclusions. The DASS was a reliable and valid instrument for assessment of the constructs it was intended to measure.

With regards to independent/interdependent self-construals, The most widely used measure consistent with a two-dimensional model is Singelis' (1994) Self-Construal Scale (SCS). According to Singelis, prior to the development of this scale, most individualism-collectivism scales were based on a single bipolar dimension. Therefore, the goal for the development of the SCS was to ascertain that the two aspects of the self can coexist within an individual. Singelis (1994) based his two-dimensional model on the theoretical concepts of independence and interdependence presented by Markus and Kitayama (1991). The goal was to measure independent and interdependent self-construals at an individual level. Singelis borrowed items from existing measures and developed new items that related to the two components. The scale consists of 24 items, 12 per subscale. The respondents use 7-point ratings (1 = strongly disagree to 7 = strongly agree). Below is a summary of studies that have used SCS.

Table 2.4. Summary of SCS studies

Authors	Country	Sample size	Results/ Conclusions
Singelis (1994)	USA	N=364	Individualistic societies = status. Collectivist societies = duties.
Fernandez et al. (2005)	29 nations	N=5688	Interdependence = collectivist societies. Independence = individualistic cultures.
Hardin (2006)	USA	N=810	Reported multidimensional self-construals:

Strength and Difficulties Questionnaire (SDQ) is a brief 25-item scale. It covers behavioural and emotional issues and also asks about difficulties in these areas causing distress and social problems. It has been widely used internationally and has been translated in over 40 languages. Results from SDQ can successfully predict psychiatric disorders in three groups by rating each group as unlikely, possible or probable (Goodman et al, 2000). The groups are conduct—oppositional disorders, hyperactivity—inattention disorders and anxiety—depressive disorders. By combining the predictions for all three groups, a general prediction can be issued about presence/absence of particular disorder. Below is a brief summary of some SDQ studies.

Table 2.5. Summary of SDQ studies

Authors	Country	Sample characteristics	Results/Conclusions
Goodman (1997)	UK	N=403, 4-16 years	Good psychometric properties. Offers a compact format coverage of inattention, peer relationships, and prosocial behaviour.
Bourdon et al. (2005)	USA	N=10367, 4-17 years	Good validity and internal consistency. SDQ is efficient screener for child and adolescent mental health problems.
Hawes and Dadds (2004)	Australia	N=1359, 4-9 years	Sound psychometric properties. Support was found for the original structure of the measure.

The Centre for Epidemiological Studies Depression Scale for Children (CES-DC) is a self-report depression questionnaire. The range of scores is between 0 and 60. It asks respondents about feeling and actions during the past week and each response is scored as follows: 0 = “Not At All” 1 = “A Little” 2 = “Some” 3 = “A Lot”. Specific items such as 4, 8, 12, and 16 are phrased positively therefore scored in the opposite order: 3 = “Not At All” 2 = “A Little” 1 = “Some”0 = “A Lot”. High CES-DC scores indicate elevated levels of depression. Weissman et al. (1980) proposed the cut-off score of 15 to be indicative of depressive symptoms in children and adolescents. Below is a brief summary of some CES-DC studies.

Table 2.6. Summary of CES-DC studies

Authors	Country	Sample characteristics	Results/Conclusions
Faulstich et al. (1986)	USA	N=148, 8-17 years	Good psychometric properties. 3 distinct factors: behavioural, cognitive component +a happiness dimension.
Barkmann et al. (2008)	Germany	N=2863, 7-17 years	Good factorial validity and stability
Jackson et al. (2013)	USA	N=986, 11-14 years	Reliable measure for levels of depression

Social Support Scale measured perceived support available to respondents from people around them. 4-point Likert scale ranging from 1"Not at all" to 4 "A great deal" was used. Social support is defined as a multidimensional construct that consists of physical and instrumental assistance, attitude conveyance, emotional and psychological support and resource and knowledge sharing (Lopez and Salas, 2006). Below is a summary of studies employing Social Support Scale.

Table 2.7. Summary of Social Support Studies

Author	Country	Sample Characteristics	Results/Conclusions
Malecki and Kilpatrick (2003)	USA	N=263, 10-14 years	Emotional and instrumental support scores were highest from classmates and close friends. Supportive behaviours from parents contributed to students' adjustment.
Wilson et al. (1999)	USA	N=48, 13-16 years	Emotional and instrumental support produce different effects in boys and girls.
Rigby	Australia	N=845, 12-16	Low social support

(2000)	years	contributed significantly and independently to relatively poor mental health.

2.4.2. Qualitative measures

The interviews, conducted with 20 participants (10 adolescents and 10 adults) were unstructured. Therefore after asking the core question: ***How does anxiety make you feel***? , each participant determined the flow of the interview. They were probed for more details with the question: "Can you tell me more about this?". For the adults one additional question was added: ***What made you anxious when you were an adolescent?*** Details about the interviewing process can be found in Chapter 5 (Study 3).

2.5. Data collection

For Study 1 and Study 2 surveys are used. Surveys are questionnaires (or a series of questions) that are administered to research participants who answer the questions themselves (self-report data). Surveys are easy to administer and their main advantage is that they offer the researcher a cost-effective and fast way to understanding how a group or population feels about certain topics (Stangor, 2004).

2.6. Data analysis

For Study 1 and Study 2 quantitative data was analysed using IBM SPSS Statistics for Windows, Version 19.0. Confirmatory factor analysis, correlation analysis, Multivariate Analysis of variance (MANOVA) were used to answer the research questions for each study (For Study 1: What are the similarities and differences in prevalence and correlates of anxiety and depression among

adolescents and adults? For Study 2: What are the mental health literacy rates across these groups and in what ways they influence attitudes and help-seeking behaviour?)

For Study 3, an Interpretative phenomenological analysis was employed as outlined by Smith (2011).

2.7. Ethical considerations

Prior to data collection, all ethical issues with regards to the project were considered and the project has received full ethical Approval by the Subject Area Ethics Working Group (SAEWG) at the University of Roehampton (Ref. PSY 10/050). This project was designed according to British Psychological Society ethical guidelines for research with human participants. These include:

- Consent:

  "… where research involves any person under 16 years of age, consent should be obtained from parents or from those in loco parentis…." (British Psychological Society, Ethical principles for conducting research with human participants, section 3.3). Because the study included adolescents (13 - 17 year olds), the parents or those in loco parentis were asked to give their written consent for their child's participation.

- The right to withdraw from the investigation:

  "…the participant has the right to withdraw retrospectively any consent given, and to require that their own data, including recordings, be destroyed…" (British Psychological Society, Ethical principles for conducting research with human participants, section 6). These were addressed in the briefing and in the consent

form. If the participant decided at any point to withdraw his/her data was to be excluded from further analysis and publication.

- Confidentiality:

  "In the event that confidentiality and/or anonymity cannot be guarantee, the participant must be warned of this in advanced of agreeing to participate". (British Psychological Society, Ethical principles for conducting research with human participants, section 7.1). This was addressed in the briefing and consent form.

  In addition to these, it was ensured that the participants were given ample opportunity to understand the nature, purpose, and anticipated consequences of their participating in this research.

  The confirmation from Subject Area Ethics Working Group (SAEWG) is in Appendix I and the Report of the SAEWG is in Appendix II. All letters for participation, consent forms and debrief forms have been approved by SAEWG. These can be found as follows: A letter to the Head Teacher +Permission Form (Appendix III), A letter to the Employer + Permission Form (Appendix IV), A letter to the parent (Appendix V), Consent Form Adolescents (Appendix VI), Consent Form Adults (Appendix XVII), Debrief Form Adolescents (Appendix VIII), Debrief Form Adults (Appendix IX), Debrief Form Parents (Appendix X), Parental Consent Form (Appendix XI). In addition a Risk Assessment Form was completed prior to data collection. The project was assessed as being low risk to both the participants and the researcher (Appendix XII).

  The English version of the questionnaires was adapted and translated according to guidelines that are widely accepted for the successful translation of instruments in cross-cultural research (Brislin, 1970). One bilingual translator who was also a native speaker blindly translated the questionnaires from the original language

(English) to the second language (Bulgarian). Another bilingual person translated it back to the original language (Bulgarian back to English). Differences in the original and the back-translated versions were discussed and resolved by joint agreement of both translators.

CHAPTER 3: PREVALENCE AND CORRELATES OF ANXIETY AND DEPRESSION IN BULGARIAN ADOLESCENTS AND ADULTS (STUDY 1)

Research questions:

- What are the prevalence rates of anxiety in Bulgarian adolescents and adults?
- What are the prevalence rates for depression in Bulgarian adolescents and adults?
- Can cross-cultural aspects, social support and self-construals explain the similarities and differences in these age groups?

3.1. Literature review

3.1.1. A brief Introduction

Adolescence is known as a period of transition between childhood and adulthood. It is a key stage for physical and psychological development and is characterised by many and different changes. The body and mind both change to prepare the individual for economic and social independence. It is during adolescence when people develop their identity and acquire the variety of skills compulsory for adulthood roles and relationships (Christie andViner, 2005). According to Apter (1990) one of the main tasks of adolescence is to achieve an identity— not only knowledge of who we are, but a clear idea of the range of what we might become, a combination of self-references by which we can make sense of our responses, and justify our decisions and goals. The most important step from concrete to abstract thinking and reasoning is also taken during adolescence. All these new experiences, feelings and role rehearsing put a lot of pressure on young people and may cause difficulties. Adolescents are usually very vulnerable and easily influenced by their social surroundings. Blos (1962) described adolescence as the time when "the limitless future of childhood shrinks to realistic proportions, to one of limited chances and goals; but, by the same token, the mastery of time and space and the conquest of helplessness afford a hitherto unknown promise of self-realization. This is the human condition of adolescence."

Adolescents need to undergo a very difficult adjustment process in order to accommodate all these changes and this is when various mental health issues might arise. It is important to accentuate on good behaviour patterns during this stage as the foundations for adulthood behaviour are established during this period. It is not simply a case of "it is just a phase" or "they will grow out of it" because antisocial behaviour, drug taking, career choices, etc. will most certainly have a lasting negative or positive impact on every individual's life. "If they are to

arrive at psychological adulthood, all adolescents must face the loneliness and heartbreak of bidding "farewell to childhood" emphasising on the “moral authority of society in which they live” (Kaplan, 1984). Adults have a powerful influence over adolescents. Adults are what the adolescent is striving to become - this is why young people desire independence so strongly. However, as they are not equipped to deal with the complications in adults’ world, they often behave in a confused, illogical or rebellious way.

Adolescents are not children and they are not adults even though they make look like them. They have not got the instruments to fully understand the complexity and consequences of their behaviour and human behaviour generally or the control they may exert over certain issues (Finkenauer, 2005).

According to WHO/Adolescent development, 2015, “Adolescents depend on their families, their, communities, schools, health services and their workplaces to learn a wide range of important skills that can help them to cope with the pressures they face and make the transition from childhood to adulthood successfully. Parents, members of the community, service providers, and social institutions have the responsibility to both promote adolescent development and adjustment and to intervene effectively when problems arise.” Adolescence, due to its problematic and eventful nature gives a prerequisite for development of certain psychological conditions including the anxiety and depression disorders that were explored in this study.

The turbulence and constant changes of adolescence give way to adulthood where many of the psychological issues persist (Pine et al., 1998). Adults also undergo significant emotional and psychological changes in any stage of adulthood: early, middle and late adulthood. I have focused on early and middle adulthood for the purposes of this study. Early adulthood is usually associated with the willingness

to find our place in the world by gaining independence, form relationships, develop intimate relationships and (usually) marry and start a family. Psychological well-being throughout our lives usually depends on the choices we make during this stage and the ability to form successful relationships. Emotional consequences significantly impact our view of ourselves. Erikson (1968) argued that unsuccessful relationships lead to isolation, emotional problems, loneliness and depression.

3.1.2. Prevalence, comorbidity and gender effects of anxiety disorders and depression

3.1.2.1. Prevalence, comorbidity and gender effects in children and adolescents

Research indicates that anxiety disorders and depression are highly prevalent in childhood and adolescence. Cartwright- Hatton et al. (2006) reported in a review that epidemiological studies vary in the prevalence rates that they report for children due to employing different methodology but overall anxiety disorders appear to be more common than depressive disorders.

Cohen et al. (1993) studied age and gender patterns for different psychiatric disorders in a general population sample of respondents aged 10-20 years. He found some developmental stage-associated risks with major depression in girls. Major depression pattern was suggestive of a role for the onset of puberty.

In a study by McGee et al. (1990) the prevalence of DSM-III disorders was studied in a general population sample of 943 adolescents aged 15 years. Prevalence rates of disorder of 25.9% for girls and 18.2% for boys were found. Overanxious disorder, nonaggressive conduct disorder and simple phobia were the most prevalent disorders. They concluded confirmation was more likely where

the adolescent was less socially competent, the mother was depressed or the family was low in social support.

In a longitudinal community study in the USA conducted by Costello et al. (2003) the prevalence and development of psychiatric disorders from age 9 through 16 years were examined over several years. On average 36.7% of participants (31% of girls and 42% of boys) had at least 1 psychiatric disorder. The averages measures for anxiety disorders were 9.9 % (12.1 % for girls and 7.7.% for boys) whereas for depressive disorders the number was 9.5 % (11.7 for girls and 7.3 % for boys). Some disorders (panic, social anxiety, depression, and substance abuse) increased in prevalence over the study period, whereas other (separation anxiety disorder) decreased. Those with psychiatric disorder diagnosis at an earlier point were about 3 times more likely to have one at subsequent stages. Such risk was high among both girls and boys, but it was significantly higher among girls. Continuity of the same disorder was significant for all disorders with the exception of specific phobias.

According to Anderson et al. (1987) who collected data from 792 11 year-olds, the rates of anxiety disorders were: 3.5% for separation anxiety disorder, 2.9% for overanxious disorder, 2.4% for simple phobia, and 1.0% for social phobia. Lewinsohn et al. (1993) collected data on the point and lifetime prevalences, 1-yr incidence and comorbidity of depression with other psychiatric disorders in a randomly selected sample of 1,710 high school students at point of entry and 1,508 at the 1-year follow-up study. 9.6% had a current disorder, over 33% had experienced a disorder over their lifetimes (31.7% of this group also had a 2nd disorder). Relapse rates were high for all disorders (e.g. unipolar depression (18.4%) and substance use (15.0%). In all age groups female respondents had higher rates for anxiety disorders, unipolar depression, eating disorders and

adjustment disorders whereas males had higher incidence of disruptive behaviour disorders.

The frequency, comorbidity, and psychosocial impact of anxiety disorders in German adolescents were examined in a study by Essau et al. (2000). Anxiety disorders and other psychiatric disorders were coded in 1,035 students aged 12-17 years were examined based on criteria from DSM-IV. Anxiety disorders rate among German adolescents was 18.6%. Phobia was the most common disorder, followed by post-traumatic stress disorder (PTSD) and obsessive-compulsive disorder (OCD) at just under 2%. Panic disorder and generalized anxiety disorder (GAD) were the least common, with rates well below 1%. Gender differences were significant –rates in girls were higher and this tendency increased as they got older. Comorbidity was common, particularly between anxiety and depressive disorders. Very few adolescents sought help for their problems even when symptoms were severe. Furthermore, in an additional examination of German adolescent data focusing on social phobia, Essau et al. (1999) discovered that it was also more common in girls. However, occurrence of social fears was much higher than that of social phobia. The most common types of situations feared by German adolescents were doing something in front of other people and public speaking. Comorbidity of social phobia with depressive disorders and substance use disorders was also confirmed.

890 adolescents were followed in a study by Feehan et al. (1993) between 15 -18 years. 65.9 % of the respondents who had anxiety disorder at the age of 15, had some psychological disorder at the age of 18 and 38.6% had a diagnosis of anxiety disorder 3 years on. Keller et al. (1992) assessed the lifetime psychiatric histories of 275 children and found that 14% of the children had a history of anxiety disorder. High comorbidity with depression and other psychiatric

disorders were observed. Long recovery periods were reported with about 46% of respondents with anxiety disorder taking longer than 8 years to recover. The median age of onset for separation disorder and overanxious disorder was only 10 years for overanxious disorder and 8 years of age for separation disorders.

3.1.2.2. Prevalence, comorbidity and gender effects in Adults

Regier et al. (1998) examined the prevalence of anxiety disorders and their co-occurrence with other mental, addictive, and physical disorders. 20,291 adult individuals aged 18 and over from the Epidemiologic Catchment Area (ECA) study were analysed. They explored current disorders, one month and one year incidence, and one year and lifetime prevalence of anxiety, mood, and addictive disorders. As a result they were able to identify the onset and offset of disorders within the one-year prospective period. About half (47.2%) of those respondents meeting lifetime criteria for major depression also have met criteria for a comorbid anxiety disorder. The average age of onset of any lifetime anxiety disorder (16.4 years) and social phobia (11.6 years) among those with major depression was much earlier than the onset age for major depression (23.2 years) and panic disorder. Social and simple phobias appeared to have an early onset in adolescence. They can also predispose adolescents with anxiety disorders to be vulnerable to major depression and addictive disorders in adulthood.

Bourdon et al. (1988) analysed gender differences in phobias based on ECA community survey. 18,572 respondents, aged 18 and over, were questioned about 15 phobic symptoms matching DSM-III criteria for agoraphobia, social phobia, and simple phobia. Significant gender differences were observed with women showing higher prevalence rates of agoraphobia and simple phobia. The least

prevalent phobias was social phobia – no gender differences were reported. The most common phobias for both genders were "spiders, bugs, mice and snakes," and "heights." The most notable differences between men and women were found on the agoraphobic symptoms of "going out of the house alone" and "being alone," and on two phobia items, the fear of "any harmless or dangerous animal," and "storms." With regards to the age of onset, past recall of symptoms, fear reporting and telling doctors about phobia symptoms, no gender differences were found. Mean age of onset was significantly older for agoraphobia than for social or simple phobia, although all phobias presented onset at an early age.

Kessler et al. (1994) examined estimates of lifetime and 12-month prevalence of 14 DSM-III-R psychiatric disorders from a general population sample (National Comorbidity Survey) in the USA. 8000 participants aged 15-54 were assessed. Results indicated that about 50% of respondents reported at least one lifetime disorder. 30% reported at least one 12-month disorder with the most common disorders being major depressive episode, alcohol dependence, simple phobia and social phobia. 14% of respondents had a history of three or more comorbid disorders and more than half of all lifetime disorders occurred in this group. Participants showed that less than 40% of those with a lifetime disorder had ever received professional treatment. For the group who had recent disorder in the last year that percentage was less than 20%. Women had elevated rates of affective disorders and anxiety disorders whereas men had higher rates of substance use disorders and antisocial personality disorder. For both genders the majority of disorders declined with age and higher socioeconomic status. Similar results were obtained through The Canadian Comorbidity Survey by Bland et al. (1988). 3,258 adults were assessed. Results suggested that about 20% had a diagnosis and about 33.8% of the population had one or more DSM –III diagnoses. The most common

lifetime disorders was alcohol dependence, followed by phobia and major depressive episode. Significant gender differences were observed. Men were more likely to have had substance use disorders and antisocial personality disorder. Women were more likely to have had major depressive episode, agoraphobia, simple phobia and dysthymia. Those who were married had generally lower lifetime prevalence. The lowest prevalence were observed in those aged 65 and over.

3.1.3. Correlates and cross-cultural aspects of Anxiety and Depression. The role of social support and self-construals in Adolescents and Adults

Apart from examining the prevalence, comorbidity and gender effects in both age groups, other factors need to be considered in order to understand the multiple aspects of anxiety and depression.

3.1.3.1. Social support

Social support is crucially important when people experience any form of psychological disorder, as they need to get help and support from close family, friends and health professionals. "Social support" is a broad term used to describe social integration and relations. Practically, this applies to the number of people who actually support or eventually would support an individual and to the quality of one's social relationships. It is important to distinguish that "social support" measures also the individual's perception of the availability of such support and support actually received from others. This depends on several issues: reciprocity, frequency of social interaction and the sense of closeness and belonging. (Schwarzer and Leppin, 1991).

Several definitions for social support exist in literature. It is seen as assistance with coping, as help provided by others or exchange of help. There are different

types of social support: 1. instrumental (assist with a problem), 2.informational (provide advice), 3.emotional (provide reassurance) and 4.tangible (give goods) (Kaptein andWeinman, 2003). According to Rook (1990), health and well-being are not simply the result of receiving support, but are a result of active participation in a social context. Rook emphasises on mutual support by exploring the nature of giving and receiving support, a social process that creates stable social ties or "companionship". The positive social context is viewed as more important than help provision itself.

It is vital to distinguish between actual support and perceived support. The first refers to real help received within certain time frame while the latter is somewhat hypothetical and refers to what might happen in a period of need. Therefore both constructs might refer to completely different and unrelated contexts (Newcomb, 1990). Expecting support in the future appears to be a stable personality trait According to Sarason et al. (1983) expecting support at some point in the future is a stable characteristic related to optimism but actual support is related to past events and the level of support received then.

Helsen et al. (2000) examined the effect of parental and friends' social support among 2918 adolescents and young adults aged 12 to 24 years with regard to emotional problems. Results suggested that parental and friends' support seem to be function as almost independent support systems. The degree of perceived support changes in the expected direction (with parental support decreasing and friends' support increasing) during early adolescence. However, parental support can be considered the best indicator of emotional problems during adolescence. The effect of friends' support appeared to depend slightly on the level of perceived parental support, with the high parental support group showing a slightly positive

effect of friends' support, and the low parental support group showing a negative effect of friends' support.

3.1.3.2. Self-construals

Social support varies across cultures because of different cultural values. According to Markus and Kutayama (1991), Eastern and Western cultures value and condone contrasting behaviours that may give direction to psychological problems. There are differences in norms and expression of emotions. To explain these they defined self-construals as result of comparison between cultures. Western cultures see the self as independent (individualist) and separate from his/her social context, therefore this representation is called an independent self-construal. In Eastern cultures the self is seen only as a part of wider social context (collectivist) – hence the interdependent self-construal. Kim et al. (2008) argued that these differences determine whether people use social support, the type of support they choose and the effectiveness of social support seeking. People in the more individualistic cultures may ask for social support relatively easily because they believe in the pro-active nature of the individual and their active role in their own well-being. In contrast, people in collectivistic cultures approach such problems with caution and are unwilling to burden their social networks, because they emphasise on social obligation rather than individual needs.

Singelis (1994) examined 364 American students of mixed ethnic origin (Caucasian and Asian Americans) by using both independent and interdependent subscales. The interdependent subscale was a better predictor than ethnic group alone. Asian Americans and those with higher interdependent scores attributed more influence to the situation than Caucasian Americans and those with lower interdependent scores. The author argued that successful intercultural interaction

depends largely on the ability to see causes of behaviour in the same way as the individual from a particular culture.

Uchida et al. (2008) conducted two studies. The first study assessed 160 Euro-American undergraduates, 243 Filipino undergraduates and 256 Japanese undergraduates. They predicted that perceived emotional support would have a less beneficial effect on well-being among Euro-Americans than among Asians. They found that this was true among both Japanese and Filipinos and the effect of perceived emotional support on positive affect remained highly significant even when the effect of self-esteem was controlled. In contrast, among Euro-Americans the effect of perceived emotional support on positive affect was weak compared to the two Asian groups. In the second study 56 Caucasian Americans and 80 Japanese adult participants (Mean age 48.61) were examined. The effect of perceived emotional support was significant and positive in all cases for Japanese but was substantially weaker and non- significant in all cases for Euro-Americans. This was true regardless of whether the effect of self-esteem was controlled.

Despite all the assessed evidence of substantial cross-cultural exploration of the prevalence and correlates of anxiety and depression in different parts of the world, as of present date these aspects have not been explored in a Bulgarian general population sample. This study addresses gaps in knowledge related to these particular assessments in Bulgarian adolescents and adults.

3.2. Study aim

The overall aim of this study is to examine the prevalence and correlates of anxiety and depressive symptoms among adolescents and adults in Bulgaria. The correlates to be examined include: gender, age, social support and self-construals.

3.3. Method

3.3.1. Procedure and Participants

Approval to conduct the present study was obtained from the University of Roehampton Ethic Board. The approval for the project can be found in Appendix I: Approval for ethics application (PSY 10/050) and the report of the Ethic Working Group is in Appendix II.

In this study, schools and employment companies were randomly selected from a telephone directory book for Central and Northern Bulgaria in order to recruit adolescent and adult participants. A total of 10 schools from urban and suburban schools in Veliko Tarnovo city region in Bulgaria were approached and the study's aims and design were explained. Of the ten schools that were approached, eight agreed to participate. A total of 6 employment companies were approached, 3 agreed to participate. Once School/ Employer approval was obtained, a meeting was arranged with the Head teachers/ Managing Director respectively. This allowed them to ask any questions which he/she may have about the study, and to discuss the "practical" aspects of running this study (e.g., room availability, schedule of the study to take place, etc). Once the Head teacher/ Managing Director agreed that the study can take place in his/her school or employment premises, arrangements were made to distribute consent forms. A letter to the parents of the adolescents together with a parental consent form. Eight hundred and fifty adolescent forms and 320 adult forms were distributed, however, signed consent forms were received from 708 adolescents and 256 adults ; due to missing data and inclusion criteria for age (i.e, 13 to 17 years), data of 700 adolescents and 250 adults was used in the analyses. Parental written informed consent was obtained before participation in the study. Participation for both age groups was voluntary and they were not paid for participating in this study. The adolescents

and adults completed the questionnaires in a designated Classroom/Briefing room and a research assistant was available to provide assistance if necessary and to ensure independent responding.

For this paper, data of 700 adolescents (53.9% were boys and 46.1% were girls) and 250 adults (57.2 % were women and 42.8 % were men) are used. Adolescents ranged in age from 13 to 17 years (mean = 15.31 years, SD = 1.2), adults were aged between 35 and 58 (mean = 44.78 years, SD = 6.49) Most of the adolescent participants reported their religious affiliation as Christian (83.6%), 6.4% were Islam, 0.1% Judaism, 0.1% Buddhism, and 9.7% reported that they were not affiliated with any religious organizations. From the adult sample most participants reported they were married (75%) with equivalent of A level of education (44.4). Most of the adults reported their religious affiliation as Christian (90.2%), 4% were Islam, and 5.2% reported that they were not affiliated with any religious organizations. Almost all of them were Caucasian (99.6%). Almost all of the adolescents were Caucasian (93.7%); 1.3% were Roma and 5% were Turkish or other ethnic groups. Adults were 96.4 % Caucasian, 0.6 % were Roma and 3% were Turkish or other ethnic groups.

3.3.2. Measures

For adolescents the measures are: Spence Child Anxiety Scale (SCAS) (Spence, 1998), Self-construal Scale (Singelis, 1994), Strength and Difficulties Questionnaire (SDQ) (Goodman, 1997), Social Support Scale and Centre for Epidemiological Studies Depression Scale for Children (CES-DC) and Demographic Information.

For adults the measures are Spence-Essau Anxiety Scale (SpenceandEssau, 2008). Self-construal Scale (Singelis, 1994), Depression, Anxeity and Stress Scale (DASS –21) (Lovibond and Lovibond, 1995), Social Support Scale and Demographic Information.

3.4. Results

3.4.1. Adolescent data descriptives

Table 3.1 shows the means and standard deviations of the SCAS total scores and its subscales for the total sample and for boys and girls, and gender. The highest score found in the total sample was for generalized anxiety disorder, whereas the lowest was obtained in the separation anxiety subscale.

Two-way analyses of variance were conducted to determine gender and age effects. The analyses yielded a main effect of the gender for total SCAS score, $F(1, 699)=110.27$, $p < .001$, separation anxiety, $F(1, 699)=67.97$, $p < .001$, social phobia, $F(, 699)=75.15$, $p < .001$, panic, $F(1, 699)=69.02$, $p < .001$, fears of physical injury, $F(1, 699)=94.11$, $p < .001$, and generalized anxiety disorder, $F(1, 699)=93.05$, $p < .001$. These results suggested that girls significantly reported higher levels of anxiety symptoms compared to boys.

The only significant main effect of age was found significant for the panic subscale, $F(4, 699)=4.92$, $p < .001$. Further analysis showed that the youngest age groups had significantly higher number of panic symptoms than those in the older age groups. There was no significant interaction effects between gender and age found for total SCAS score and on any of the SCAS subscales.

Table 3.1. Descriptive data on the SCAS

	Total SCAS Mean (SD)	**SAD Mean (SD)**	**Socph Mean (SD)**	**OCD Mean (SD)**	**Panic Mean (SD)**	**Fears Mean (SD)**
Total sample	25.23 (14.9)	2.89 (2.8)	5.00 (3.4)	5.05 (3.7)	3.17 (3.6)	3.29 (2.9)
Male	19.87 (11.6)	2.11 (2.1)	3.95 (3.0)	4.59 (3.1)	2.06 (2.7)	2.36 (2.3)
13 years	18.07 (9.5)	1.85 (2.1)	3.41 (2.4)	4.59 (3.2)	2.30 (2.5)	2.19 (1.6)
14 years	22.57 11.7)	2.56 (2.3)	4.36 (3.1)	4.62 (3.0)	2.98 (2.8)	2.85 (2.5)
15 years	20.16 (13.8)	2.03 (2.3)	4.29 (3.4)	4.82 (3.6)	2.30 (3.2)	2.09 (3.2)
16 years	20.15 (12.1)	2.26 (2.2)	4.00 (2.8)	4.71 (3.0)	1.79 (2.7)	2.41 (2.4)
17 years	17.25 (8.03)	1.60 (1.5)	3.31 (2.9)	4.06 (2.6)	1.41 (1.6)	2.18 (2.2)
Female	31.48 (15.9)	3.79 (3.1)	3.79 (3.1)	3.59 (3.2)	4.47 (4.2)	4.37 (2.7)
13 years	35.35 (20.3)	4.70 (4.2)	6.22 (3.4)	6.54 (3.8)	5.67 (5.2)	4.76 (3.2)
14 years	29.80 (16.8)	3.38 (3.0)	5.80 (3.6)	5.32 (3.4)	4.29 (2.3)	4.40 (2.9)

15 years	30.05 (13.3)	3.56 (2.8)	5.98 (3.3)	5.32 (2.5)	4.74 (4.3)	4.08 (2.7)
16 years	33.76 (16.1)	4.06 (3.1)	6.73 (3.7)	5.60 (2.9)	4.39 (3.9)	4.82 (2.6)
17 years	29.38 (14.7)	3.60 (2.8)	6.35 (3.5)	5.00 (3.5)	3.52 (3.4)	3.81 (2.5)

Note: SCAS=Spence Children Anxiety Scale; SAD=Separation anxiety; SOCPH= Social phobia; OCD= Obsessive compulsive; PANIC= Panic disorder; FEARS= Physical injuries fears; GAD= Generalized anxiety disorder

Table 3.2 shows the mean and standard deviation of CES-DC total and its subscales for the total sample, separately for boys and girls, and for binary age (13-15 years old and 16-17 years old). The mean score of CES-DC for the Bulgarian sample was 16.2 with a standard deviation of 10.2. Within CES-DC subscales, the highest score found in the total sample was for somatic complains, whereas the lowest score was obtained in the interpersonal subscale problem.

Table 3.2 Descriptive Results of CES-DC scale in the total sample by gender and age group

	Total CES-DC Mean (SD)	**SOMA Mean (SD)**	**DEPR Mean (SD)**	**POS Mean (SD)**	**INTER Mean(SD)**

Total Sample	16.2 (10.2)	4.9 (4.1)	4.2 (4.6)	6.1 (2.6)	0.1 (1.5)
Male	14.9 (10.0)	4.5 (4.1)	3.8 (4.5)	5.8 (2.6)	0.9 (1.4)
13-15 Years	16.3 (11.1)	4.8 (4.0)	4.4 (5.2)	6.1 (2.8)	1.1 (1.6)
15-17 Years	13.8 (9.0)	4.3 (4.1)	3.2 (3.8)	5.6 (2.5)	0.8 (1.3)
Female	17.7 (10.2)	5.6 (3.8)	4.8 (4.6)	6.3 (2.5)	1.0 (1.5)
13-15 Years	17.5 (10.4)	5.6 (3.8)	4.8 (4.8)	6.1 (2.6)	1.0 (1.3)
15-17 Years	17.9 (9.9)	5.5 (3.9)	4.8 (4.3)	6.6 (2.3)	1.0 (1.6)

CES-DC Center for Epidemiological Studies Depression Scale for Children, SOMA somatic complaints, DEP depressed affect, POS positive affect, INTER interpersonal problems.

A 2 (gender) × 2 (age) analysis of variance (ANOVA) yielded a significant main effect for gender, F (1, 696) = 12.13, $p < .05$, partial $\eta^2 = .02$, for the total score. Specifically, female participants (M = 17.68; SD = 10.16) reported to have significantly more depressive symptoms than male participants (M = 14.87; SD = 10.01). However, the findings revealed no age difference in total depressive

symptoms score. Similarly, no significant interaction effect was found in total depressive symptoms.

A 2 (gender) × 2 (age) multivariate analysis of variance (MANOVA) revealed a significant main effect for gender, F (4, 693) = 4.160, $p < .05$, partial $\eta 2 = .023$ in depressive symptoms. Follow-up univariate tests showed a significant main effect for gender, F (1, 696) = 11.78, $p < .01$ partial $\eta 2 = .017$. Female participants (M = 5.56; SD = 3.81) had higher *somatic symptom scores* than did males (M = 4.48; SD = 4.12). However, neither significant effects regarding age differences nor interaction effect was found in the somatic symptoms score. Regarding the *depressive affect*, follow-up univariate tests revealed a significant main effect for gender, F (1, 696) = 8.11, $p < .01$ partial $\eta 2 = .012$. Female participants (M = 4.79; SD = 4.61) had higher scores on the depression affect than did male participants (M = 3.72; SD = 4.52). However, no significant main effect regarding age differences in the depression affect was found. Similarly, no interaction effect was found. Regarding the *positive affect*, univariate tests showed a significant main effect for gender, F (1, 696) = 7.55, $p < .05$, partial $\eta^2 = .011$, with female adolescents (M = 6.29; SD = 2.47) reporting higher positive affect scores than males (M = 5.77; SD = 2.61). No significant main effects in terms of age differences in positive affect were revealed. Similarly, no interaction effect was found. Regarding the last subscale, there were neither gender nor age differences found in terms of *interpersonal problem* score.

3.4.2. Gender and age effects in Adolescents

The bivariate correlations presented in Table 3.3 show that significant associations obtained between gender and all anxiety measures, thus: total SCAS: $r = .39$, $p < .001$; generalised anxiety: $r = .34$, $p < 001$; physical injury anxiety: $r = .37$, $p < .001$; separation anxiety: $r = .30$, $p < .001$; social phobia: $r < .33$, $p < .001$; panic agoraphobia: $r = .29$, $p < .001$; OCD: $r = .16$, $p < .01$. Since gender was coded as 1 for males and 2 for females, these positive associations suggest that female adolescents experience stronger anxiety symptoms than their male counterparts. Thus, female adolescents experience higher levels of generalised anxiety as well as higher levels of anxiety relating to physical injury, separation, social phobia, panic agoraphobia, and obsessive-compulsive disorder.

Significant negative associations were obtained between age and the total anxiety score ('SCAS') as well as three of the SCAS sub-scales: physical injury anxiety, separation anxiety, and panic agoraphobia. These results suggest that increasing age in adolescence is associated with less overall anxiety, as well as lower levels of physical injury anxiety, separation anxiety, and panic agoraphobia. Increasing age is, however, positively associated with prosocial behaviour (age-prosocial $r = .10$, $p < .01$), indicating that as adolescents increase in age, prosocial behaviour also increases.

3.4.3. Positive and negative correlations in adolescents

The strong positive correlations between the SCAS and the CES-DC ($r = .50$, $p < .001$) and between the SCAS and the SDQ ($r = .42$, $p < .001$) show that an increasing level of anxiety during adolescence is strongly associated with both increasing levels of depression and greater emotional and behavioural problems. Likewise, the positive correlations observed between the SCAS and the SDQ sub-

scales suggest that increasing levels of anxiety during adolescence is associated with higher levels of hyperactivity, less prosocial behaviour, and a greater likelihood of emotional and peer problems. Comparison of the sizes of the bivariate correlations between the SCAS and the first SDQ sub-scale shows that anxiety in adolescence is most strongly associated with emotional problems (r = .58, p < .001): the more difficulties adolescents experience in controlling negative emotions such as anger, unhappiness, and worry, the higher their levels of anxiety. The negative associations between the SCAS and the first conduct item from the SDQ (Conduct 1) and the SCAS and the independent self-construal scale (both rs = - .11, p < .01) suggest that as adolescents' anxiety symptoms increase, both the likelihood that they will 'do as they are told' and their self-perceptions of independence decrease.

Table 3.3. Bivariate correlations between SCAS, CES-DC and SDQ

Variable	**SCAS**
Gender	.39***
Age	-.09*
Interdependent Self-construal	.05
Independent Self-construal	-.11**
Conduct 1	-.11**
Prosocial	.25***

behaviour	
Emotional Problems	.58***
Peer Problems	.26***
Emotional Support	.03
Instrumental Support	-.02
Total Support	.02
CES-DC	.50***

*** $p < .001$ ** $p < .01$ * $p < .05$

Note: SCAS=Spence Child Anxiety Scale, CES-DC=Centre for Epidemiological Studies Depression Scale for Children, SDQ= Strength and Difficulties Questionnaire

3.4.4. Adult data descriptives

The descriptives presented in Table 3.4. show that levels of anxiety among the adult sub-sample (both total and sub-types) were generally normal, with mean scores for all anxiety types being considerably lower than the thresholds indicative of 'elevated' (sub-clinical) levels of anxiety . Similarly, the mean score

for depression indicates that, in general, levels of depression among adults were normal (cf. Lovibond and Lovibond, 1995). Adult participants also generally perceived good levels of social support based on the Berlin Social Support Scale. Finally, average scores on the independent and interdependent self-construal scales were moderate to high, suggesting that adult participants perceived themselves, overall, as both independent and interdependent.

Table 3.4. Adult data descriptives

Variable	***Mean***	***(SD)***
SEAS Total	24.07	(12.71)
Social Phobia sub-scale	6.30	(3.68)
Physical Injury sub-scale	4.83	(3.72)
Panic sub-scale	2.29	(2.20)
OCD sub-scale	5.84	(3.48)
Generalised Anxiety sub-scale	4.81	(2.75)

Depression sub-scale (DASS)	3.68	(3.64)
Interdependent Self-Construals	5.18	(0.73)
Independent Self-Construals	5.33	(0.79)

Note. 'SEAS' = Spence-Essau Anxiety Scale; 'OCD' = Obsessive-Compulsive Disorder; 'DASS' = Depression Anxiety and Stress Scale

3.4.5. Gender and age effects in Adults

The bivariate correlations presented in Table 3.5 show that positive associations were obtained between gender and scores on the combined (index) measure of anxiety (age-SEAS Total $r = .22$, $p < .001$), and between gender and scores on four of the five anxiety sub-scales: physical injury anxiety ($r = .30$, $p < .001$), generalised anxiety ($r = .20$, $p < .001$), social phobia ($r = .16$, $p < .05$), and panic agoraphobia ($r = .18$, $p < .01$). No significant relationship obtained between gender and scores on the obsessive-compulsive disorder sub-scale of the SEAS ($r = .05$, *ns*). Since gender was coded as 1 for males and 2 for females, these positive associations suggest that female Bulgarian adults experience stronger anxiety symptoms than their male counterparts; specifically, relative to male Bulgarian adults, female Bulgarian adults experience higher levels of general anxiety as well as higher levels of anxiety relating to physical injury, generalized anxiety, social phobia, and panic agoraphobia.

In the adult sub-sample, a significant positive correlation was obtained between age and the interdependent self-construal scale (r = .16, p < .05), showing that increasing age among adult Bulgarians is associated with stronger perceptions of interdependence. No significant associations were obtained between age and the remaining study variables in the adult sample.

3.4.6. Positive and negative correlations in adults

Examination of the bivariate correlations with the total adult anxiety scale (SEAS) shows that scores on the SEAS were positively associated with the depression subscale of the DASS (r = .52, p < .001) and were negatively associated with independent self-construals (r = -.16, p < .05), emotional support (item 3: r = -.13, p < .05; item 4: r = -.16, p < .05), instrumental support (r = - .17, p < .01), and quality of life (r = -.34, p < .001). These results indicate that, among Bulgarian adults, little social support and independence, and high levels of depression are each associated with higher levels of anxiety. The strongest correlate of general anxiety among Bulgarian adults is depression.

Table. 3.5. Positive and negative correlations in adults

Variable	**SEAS**
Gender	.22***
Age	-.01
Interdependent Self-Construals	.01
Independent Self-Construals	-.16*
Emotional support 1	.04
Emotional Support 2	-.09

Emotional Support 3	-.13*
Emotional Support 4	-.16*
Instrumental Support	-.17**
Depression	.52***

In order to examine whether adults and adolescents differed on level of anxiety symptoms, a series of independent t-tests were conducted in which sample (adults versus adolescents) was entered as the grouping variable and anxiety symptom as the dependent variable. Significant differences were obtained between adults and adolescents on all five anxiety sub-types: Relative to adolescents, adults reported significantly higher levels of social phobia (t[948] = 5.04, p < .001), physical injury anxiety, (t[348] = 5.99, p < .001), panic agoraphobia (t[948] = 2.88, p < .01), obsessive compulsive disorder (t[948] = 3.32, p = .001), and generalised anxiety (t[509] = -4.80, p < .001). However, no significant difference emerged between adults and adolescents in total anxiety levels (t[520] = -1.19, ns).

3.4.7. Is the association between age group (adult versus adolescent) and level of anxiety symptoms explained by differences between the two groups in interdependent versus independent self-construals?

In light of the above findings relating to the association between age group and levels of anxiety symptoms, I examined whether such relationship might be explained by differences between the two groups in interdependent versus independent self-construals. Firstly, two independent *t*-tests were carried out in order to test for differences between the adolescent and adult samples on independent and interdependent self-construal scores. Results showed that independent self-construal scores did not significantly differ between the two groups (*Means* = 5.33 and 5.26 for adults and adolescents, respectively), $t(948) = 1.29$, *ns*; however, there was a significant difference between the adult and adolescent samples in interdependent self-construals: Adults' perceptions of interdependence were significantly stronger ($M = 5.18$) than adolescents' perceptions of interdependence ($M = 5.04$), $t(562) = 2.46$, $p < .05$.

In light of the significant difference obtaining between the two age groups on interdependent self-construals, a series of mediated regression analyses were carried out in order to examine whether interdependent self-construals explained (mediated) the relationship between age(group) and anxiety symptoms. Procedures followed those outlined by Baron and Kenny (1986). According to these researchers, four conditions must be met in order to demonstrate mediation:-

- The predictor variable (age group) significantly impacts upon the outcome variable (anxiety symptom);
- The hypothesised mediator variable (interdependent self-construals) significantly influences the outcome variable (anxiety symptom);
- The predictor variable (age group) has a significant impact upon the hypothesised mediator (interdependent self-construals);
- The hypothesised mediator (interdependent self-construals) actually does mediate the relationship between the predictor (age group) and the outcome variable (anxiety symptom). This fourth step also enables an analysis of whether mediation is partial or complete (*cf*. Baron and Kenny, 1986).

3.4.8. **Do interdependent self-construals mediate the relationship between age (group) and total anxiety scores**?

The first regression analysis examining whether age(group) predicted total anxiety scores revealed that age group was not a significant predictor of total anxiety scores (beta = .04, *ns*), $F(1, 948) = 1.19$, *ns*. However, in light of the fact that gender (relative to age group) was a considerably stronger correlate of total anxiety scores in these data, the author examined whether the explanatory (mediating) role of interdependent self-construals in the relationship between age group and total anxiety scores might be moderated by

gender. This test of moderated mediation was carried out following Baron and Kenny's (1986) mediated regression procedures for males and females separately. With regard to the male sub-sample, the results of the first regression analysis showed that age group was not significantly associated with total anxiety scores (beta = -.03, ns), $F(1, 482) = 0.55$, *ns.* Since all four of Baron and Kenny's conditions must be met to demonstrate mediation, it can be concluded that interdependent self-construals do not explain (mediate) the relationship between age group and total anxiety scores among Bulgarian males. With regard to the female sub-sample, the results of the first regression analysis showed that age group was significantly associated with total anxiety scores (beta = .15, $p = .001$), $F(1, 464) = 11.02$, $p = .001$; however, in the second regression analysis, interdependent self-construals were not significantly associated with total anxiety scores (beta = .04, *ns*), $F(1, 464) = 0.78$, *ns.* Thus, whilst interdependent self-construals do not explain (mediate) the relationship between age group and total anxiety scores for either males or females, the results of these analyses show that the relationship between age and general (total) anxiety is moderated by gender: Adolescence is associated with heightened general anxiety (and adulthood with lower levels of general anxiety) only among females.

3.5. Discussion

The mean SCAS total score found in our study was 25.23, a result very similar to the mean scores reported in studies conducted in various countries. The mean SCAS results reported in Cyprus, Australia, Germany, the Netherlands, Japan, and Hong Kong ranged from 18.11 to 38.78 (Spence, 1998, Essau et al., 2011, Essau et al., 2008, Ishikawa et.al, 2009). The mean SEAS total score was 24.07, so there was no significant difference between the overall anxiety levels in adolescents and adults. The author's expectation to find extremely elevated levels of anxiety and depression among all age groups in

Bulgaria due to the poverty, corruption and unpleasant social climate in the country did not materialise. Perhaps it was due to the fact that after more than 25 years of democracy, Bulgarian people are on the way to recovery from the impact of economic chaos, unemployment, corruption and social challenges (Raleva et al. 2014). This could be partially contributed to the EU enlargement which saw the country joining the European Union in 2007 and provided a considerably safer social environment for Bulgaria.

A consistent finding from the adolescent sub-sample was that anxiety – general and specific types – and emotional problems had the strongest correlational relationship. This stands in contrast with the finding that anxiety correlated strongly with depression in the adult sample. As the strongest relationship of generalized anxiety among the adolescent sample was emotional problems ($r = .50$, $p < .001$) this would mean that as levels of generalized anxiety in adolescents increase, hyperactivity, emotional and peer problems, and depression also increase. However, as levels of generalized anxiety increase, the likelihood that the adolescent will 'do as they are told' decreases. Ebesutani (2006) suggested that oppositional behaviour in adolescents is very often driven by anxiety/depression and problems related to peers, parents and body image. Several possible explanations for this could be found in the specifics of adolescence. It is known as the period when important factors such as low self-esteem, loneliness and social isolation begin to emerge. Adolescents lack the emotional tools to deal with these issues as effectively as adults (Beesdo et al., 2009) and they become a major anxiety source. In adulthood, emotional problems are dealt with more successfully and they do not correlate so strongly with anxiety.

In adolescents the strongest relationship was between physical injury anxiety and emotional problems (as assessed via the SDQ) ($r = .34$, $p < .001$). As levels of physical injury anxiety in adolescents increase, self-perceptions of independence and prosocial

behaviour decrease whereas general difficulties, emotional and peer problems, perceptions of emotional and general social support, and depression increase. Although one might argue that higher levels of physical injury anxiety should be negatively (rather than positively) associated with emotional support specifically and social support more generally, my finding of positive relationships between both of these perceived support variables and physical injury anxiety makes sense when one considers that highly physical injury anxious adolescents might seek more social support. This view is supported by Geckova et al.(2003).

When it comes to separation anxiety the findings show that as levels of separation anxiety in adolescents increase, physical aggression and prosocial behaviour decrease whereas self-perceived independence, general difficulties, hyperactivity, emotional problems, peer problems, and depression increase. This complicated relationship could be a result of the physical development, drive for independence, the prominence of social and peer relations and brain development (Blakemore, 2008; Casey et al. 2008). It could also be related to adolescent temperament and experiencing various stressful events in life and coping with them. (Laceulle, 2014).

A significant difference was observed between the adult and adolescent samples in interdependent self-construals: Adults' perceptions of interdependence were significantly stronger ($M = 5.18$) than adolescents' perceptions of interdependence ($M = 5.04$), $t(562) = 2.46$, $p < .05$. Interdependence is commonly observed in Eastern collectivist societies (Markus and Kitayama, 1991). Our adult sample results showed a desire to "fit in", to adjust to the needs of the group, to oblige and commit to certain social responsibilities. All of these are associated with an Eastern model of collectivist behavior – perhaps a psychological leftover from the Communist rule.

Adolescent results indicated that increasing levels of rebellion, physical aggression, pro-social behaviour, and independence are each associated with decreased levels of social phobia. However, enhanced perceptions of interdependence, increased general difficulties, more severe depression, greater amounts of hyperactivity, and more emotional and peer problems are each associated with increased levels of social phobia. This is also consistent with many other studies (Schneier et al. 1992; Magee et al. 1996). In addition, interdependency is viewed as undesirable in adolescents who value autonomy and independence. Steinberg and Morris (2001) argued that although we use the words autonomy and independence interchangeably, in the study of adolescence they mean slightly different things. Independence generally refers to teens' capacity to behave on their own. The growth of independence is surely a part of becoming autonomous during adolescence, but autonomy means more than behaving independently. It also means thinking, feeling and making moral decisions that are truly your own rather than following along with what others believe." This is quite overwhelming for an adolescent but is a way of stepping into the adult world in Western societies, where the need to forge a new independence is critical (Baumeister and Tice, 1986; Twenge and Im, 2007). This period can be stressful for many adolescents, as it involves new emotions, the need to develop new social relationships, and an increasing sense of responsibility and independence.

Emotional problems shared its status as the strongest correlate of panic agoraphobia with the CES-DC ($r_s = .47$, $p < .001$) and was the strongest correlate for obsessive-compulsive disorder ($r = .52$, $p < .001$). It is a common pattern observed across different anxiety disorder types as observed by previous studies (Spence, 1998, Essau et al., 2011, Essau et al., 2008)

An interesting discussion point could also be derived from the average scores on the independent and interdependent self-construal scales. They were moderate to high,

suggesting that adolescents generally perceived themselves as both independent and interdependent. A lot of psychological and social changes occur in adolescence and it is difficult for to place oneself in particular category just yet.

Despite the non-significant difference between adolescents and adults' total anxiety scores, it is vital to acknowledge that adults scored significantly higher than adolescents on all anxiety sub-types levels (social phobia, physical injury anxiety, panic agoraphobia, obsessive-compulsive disorder). These scores could be partially attributed to the adults' childhood and adolescence, both of which occurred under the Communist rule. Stein (2009) suggested that elevated levels of social phobia can be attributed to a past history of behavioural inhibition. In the years of communism there was a prevalent fear of acting in a way that will be humiliating, embarrassing or even potentially dangerous for the individual who was subjected to the scrutiny of others and punished for certain behaviours (hence the physical injury anxiety) which are completely acceptable in the West. Such exposure to feared social situations in the past may subsequently invoke social anxiety and possibly panic attacks in our adult sample. In addition, Proffer (1996) suggested that there was a marked difference in the way Western Europeans (also Americans) and Eastern Europeans experienced anxiety. Western Europeans most often experienced anxiety of influence and Eastern Europeans – anxiety of physical destruction.

In adolescents, it is interesting to note the two so-called peaks for overall anxiety which occur at 13 ad 16 years of age. They are in line with Kessler et al. (2005) findings for an earlier age of onset and their age distributions for specific anxiety disorders during adolescence. Increasing age is also positively associated with prosocial behaviour (age-prosocial $r = .10$, $p < .01$), indicating that as adolescents increase in age, prosocial behaviour also increases. There could be some subtleties in this association. A study by Nantel-Vivier et al.(2009) indicated that, in adolescence, despite the continuous

development of empathy and moral reasoning, prosocial behaviours reach a plateau. Some plausible explanations have been provided for this notable change e.g. the adolescent ability to select and favour certain behaviours. In adolescence the emphasis is placed not so much on family affiliations but on peer relations. Research suggests that early maturation in adolescents has a positive impact on prosocial behaviours. These findings are true for both genders but are much more evident in male adolescents. Early puberty onset has a positive correlation with prosocial behaviours. (Carlo et al., 2012).

In line with numerous previous studies (Essau et al., 2000, Keller et al., 1992, Su et al, 2008, Muris et al., 2002), girls results show much higher anxiety levels than boys. Within the SCAS subscales, girls scored higher rates for all subscales except for obsessive-compulsive symptoms (Essau et al., 2000, Keller et al., 1992, Su et al, 2008, Muris et al., 2002, Wren et al., 2007). It has been suggested that the psychological and social challenges and expectations during adolescence tend to be more demanding for girls than for boys and this results in increased levels of anxiety (Eagly and Steffen, 1984). Ahmad et al.(2013) have observed that girls in general are more concerned with physical appearance and relationship outcomes than boys. This put them at greater risk for anxiety and self-esteem issues. In addition, adolescent girls were more susceptible to fear of evaluation in social setting and that caused anxiety among them. Hankin (2007) also argued that adolescent girls encounter more so called "stressors" in life, especially in their interpersonal relationships, than boys. This, combined with their much more pronounced reactions to those pressures might account for girls' higher depression levels.

The gender differences are evident also in our adult sub-sample with women reporting higher levels of anxiety and depression than men. Research has produced evidence that these differences in rates are related to the different social roles of men and women (Rosenfield, 1980, Ruble et al. 1993). Such factors are important and vary among

cultures. In addition, several stereotypes contribute to gender differences. Fabes and Martin (1991) stated that women are more expressive than men of their sad or fearful feelings. This stereotype may act as a schema resulting in women behaving in a manner consistent with such expectation. Brody and Hall (1993) suggested that stereotypes are reinforced from an early age (boys' expression of fear is depicted negatively whereas girls are expected to express sadness and fear). Socialization practices associated with these stereotypes develop and sustain differences in anxiety and depression across both genders. Also there could be a biological explanation for these findings. McHenry et al. (2014) found evidence for pervasive sex differences in pathological conditions, including anxiety and depressive disorders, with females more than twice as likely to be afflicted. They concluded that gonadal hormones may be a major factor in this disparity, given that women are more likely to experience mood disturbances during times of hormonal flux. Higher levels of testosterone in men may have protective benefits against anxiety and depression.

3.5.1. Limitations

There are some limitations in the present study and they need to be outlined and considered during our findings interpretation.

First, 13 to 17 year-olds and 35 to 55 year-olds were recruited in this study so it is unclear if these findings can be generalized to other groups and populations. Therefore, in order to assess this limitation, at least to a certain extent, the author plans to conduct a similar study among other age groups across the population of Bulgaria.

Second, for the purposes of this study the participants were recruited from schools (general population) and employment companies (general population) and not from clinical settings. Diagnostic interviews were not carried out, therefore the clinical

efficacy and value of the Bulgarian version of the instruments has not yet been researched profoundly.

Third, the data collected relied on self-report measures. These are usually associated with subjectivity and social desirability but they are universally accepted as one of the best methods to assess psychopathological problems. Given that anxiety and depression are internally-derived and experienced individually, the use of self-report questionnaires seems appropriate.

Fourth, the problems usually associated with surveys include the fact that respondents may not feel encouraged to provide honest answers, especially if they portray them in an unfavourable light. Non-responses also occur often, combined with the possibility that due to boredom or lack of time, respondents may not select the answers which truly represent what they think (Roberts, 2007). There is also the individual interpretation of questions which could reflect on the collected data quality.

Fifth, the present study did not explore the test-retest reliability of the Bulgarian translation of the measures. Thus, measurement stability of these instruments across time is not known.

Finally, the samples may not be representative of all adolescent and adult groups in Bulgaria, as they were conducted in only one region of the country.

3.5.2. Directions for future research

As already mentioned, a similar study needs to be conducted across different age groups, region and settings (clinical?) in Bulgaria in order to gather data for comparison. Recruiting multiple informants and examining the test-retest reliability need to be considered also. And finally, a qualitative study might complement this

quantitative data and give a better insight into the adolescents' and adults' feelings of anxiety and depression (This was also conducted by me as a part of this thesis).

CHAPTER 4: MENTAL HEALTH LITERACY ABOUT DEPRESSION IN BULGARIAN ADOLESCENTS AND ADULTS (STUDY 2)

Research questions:

- What are mental health literacy about depression rates among Bulgarian adolescents and adults?
- Which factors determine mental health literacy in Bulgarian adolescents and adults?

4.1. Literature review on mental health literacy about Depression

Human health is a combination of several integrally connected aspects which are equally important to the overall wellbeing of an individual. According to Lefterova (2014) these aspects are: physical status, personal health, social health, spiritual health, emotional health and mental health. Having adequate knowledge about the latter is of crucial importance due to the high prevalence of different mental disorders. It has been argued that each one of us will either develop some of these conditions or know someone who has a mental disorder. That is why it is crucially important that every individual acquires certain knowledge to allow them to identify the symptoms of these conditions and to seek appropriate advice and treatment for themselves or for the people

within their social circles. According to Jorm (2000) mental health literacy is "knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognize specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking."p.396

'Help-seeking' was defined by Barker (2007) as:

Any action or activity carried out by an adolescent who perceives herself/himself as needing personal, psychological, affective assistance or health or social services, with the purpose of meeting this need in a positive way. This includes seeking help from formal services – for example, clinic services, counsellors, psychologists, medical staff, traditional healers, religious leaders or youth programmes – as well as informal sources, which includes peer groups and friends, family members or kinship groups and/or other adults in the community. (Barker, 2007, p. 2)

People's beliefs about causes, outcomes and defining characteristics of a disorder determine their treatment seeking behaviour. Social environment, education, religion, cultural values and access to professional help are also considered contributing factors. (Ganasen et al. 2008). These are particularly important for young people as adolescence is known as the period when many psychological disorders have their first onset. According to et al. (2007) these are attention-deficit/hyperactivity disorder, substance use disorders, oppositional-defiant disorder, conduct disorder and anxiety and depressive disorders.

4.1.1. Mental health literacy in adolescents

4.1.1.1. Adolescent recognition of depression

Adolescent levels of recognition of depression have been explored in a number of studies. Burns and Rapee (2006)examined the mental health literacy of a group of 202 adolescents aged 15-17 years. They were asked to recognize symptoms of depression in their peers through five different scenarios of young people. Respondents showed a limited ability to correctly recognize and label depression, although they were able to identify depressed and non-depressed scenarios. Other research studies supported these findings. In a survey examining various aspects of mental health literacy among adolescents from Eastern USA, Olsson and Kennedy (2010) respondents were introduced to brief scenarios about adolescents experiencing negative emotions and corresponding behaviours. Adolescents were asked to identify the problem and state how they would react to a peer who had such a problem. The results indicated that levels of recognition of mental disorders were low (42.4% identified depression as 'a mental health problem or illness'). Those who recognised the disorder were three to four times more likely to say they would initiate help-seeking behaviour, such as telling an adult about the problem.

Accurate labelling was also identified as a problem in a study of 2802 young Australians aged 15-25 by Wright et al. (2012). They investigated the importance of accurate labelling for various mental health problems. For the depression vignette, use of the accurate label ‘‘depression’’ predicted a preference for help from a counsellor and a psychologist. ‘‘Depression’’ was the only label to predict a belief in the helpfulness of anti-depressants while other common labels such as ‘‘stress’’, ‘‘drugs’’ and ‘‘physical problem’’ predicted a belief that they would not be helpful. Another action predicted by accurate labelling was a belief in the helpfulness of cutting down on use of alcohol and substances to treat depression. The correct label consistently predicted a preference for professionally recommended forms of help, psychological therapies and medication.

Similar findings were reported from an earlier study by Wright et al. (2007) where associations between the accurate labelling of depression by young people and their help-seeking, treatment and self-help preferences were examined. 1207 young Australian people aged 15-25 took part in this study about the effectiveness of common labels. Results indicated that most accurate labelling was able to predict a preference for professionally recommended forms of help, medications and psychological therapies. More general labels such as ‘‘stress’’ and ‘‘shy’’ determined reduced likelihood of seeking help if the young person were to experience a problem similar to the vignette scenario. Furthermore, these general labels were associated with the adolescents considering anti-depressants to not be helpful to treat depression.

The inability to recognise depression correctly among young people was also observed in a study by Loureiro et al. (2013) where 4938 Portuguese young people aged 14-24 years were presented with a depression scenario. Depression was the most prevalent answer (61.1%), but a significant number of respondents gave answers such as stress (47.3%), psychological/mental/emotional problems (40.8%), nervous breakdown (33.8%) and anorexia (16.4%). About 22.7% indicated that the person from the vignette had a problem. Only 5.5% of respondents stated that Joana’s problem was a mental illness. 14.8% considered that it was an age crisis, 2.72.7% reported that they did not know what it is and 4% reported that there is nothing wrong with her.

The problem with recognition of depression is further acknowledged in a study by Lam (2014). In a sample of 1678 Chinese students aged 13-17 years, only 275 (16.4%) had adequate mental health literacy level and were able to identify depression correctly and 248 respondents (14.8%) were classified to have moderate to severe depression. Results indicated that young people who had experienced moderate to severe level of depression in the previous week were more likely to have an inadequate level of mental health

literacy. Adolescents mental health literacy was affected by a lack of mental health education designed to target young people in their areas. Young people who displayed depressive symptoms, consciously or unconsciously, mislabelled the symptoms as some other mental or physical health problems and incorrectly identified the vignette. This group also expressed a negative attitude towards help-seeking, mainly due to lack of knowledge and understanding of the symptoms they have experienced or because of the stigmatisation associated with mental health problems.

All this evidence suggest that mental health literacy is especially salient during adolescence when individuals shape their health related behaviours and start learning to monitor and control their own health.

4.1.1.2. Beliefs about helpfulness of actions and treatments

In a survey of 3746 young Australians (aged 12-25 years), Yap and Jorm (2012) examined whether mental health first aid knowledge and beliefs of young people translate into actual behaviour when it comes to helping a close relative or friend with mental health problem. Participants reported on their first aid knowledge and beliefs about depression, depression with alcohol misuse, psychosis and social phobia. During a follow-up interview, they reported on real actions they had taken to help a significant other with a similar mental health condition. The results indicated that first aid knowledge and beliefs are valid predictors of subsequent actions taken by participants. Believing in the helpfulness of actions (appropriate or not) increased the likelihood for young people to take these actions. Yap and Jorm (2012) concluded that there were marked gender differences in beliefs and subsequent action, with young males receiving poorer quality mental health First Aid than females. The authors also highlighted the importance of using belief measures and their potential effectiveness on behavioural change by securing

timely assessment and appropriate assistance with risk and crises in others with mental health problems.

The gender differences in mental health literacy and help-seeking behaviour were observed also in Cotton et al. (2006). 1207 young Australians aged 12-25 years (539 males and 668 females) took part, 606 respondents were presented a depression vignette and 601 were presented a psychosis vignette. Female respondents (60.7%) were significantly more likely to correctly identify depression. The figure for male participants was 34.5%. Females were significantly more likely to view vitamins, minerals or herbal supplements to be helpful for the treatment of depression whereas males were more likely to favour sleeping pills and tranquillizers.

Raviv et al. (2000) reported similar results with regards to help-seeking. 512 Israeli adolescents (219 males, 293 females) in grade 10 were examined. Their willingness to seek help from five sources was evaluated with respect to themselves and others. Minor and severe health problems were considered. Results indicated that adolescents were more willing to refer another person than themselves to most of the sources of support. These differences were more pronounced for severe problems and concerned referrals to psychologists, school counsellors and teachers. Females were more willing than males to seek help from their friends and family. Help-seeking behaviour was positively related to willingness to seek help from different sources of support.

In a similar survey repeated consequently among 3021 young Australians aged 15-25, Yap et al. (2012a) examined beliefs about preventive strategies. They used the views of health professionals (Jorm et al., 2010) as a standard for evaluating young people's prevention beliefs. The majority of respondents believed that close contact with family and friends and physical activity would be helpful. Younger respondents from the sample (adolescents), female respondents, those who had experienced mental health problems

recently and those without access to mental health information expressed beliefs associated with limited mental health literacy. Yap et al. (2012a) argued that younger respondents had poorer mental health literacy and supported avoidance strategies. Females tended to choose emotion-focused coping, including spiritual and religious beliefs. Those who had experienced a mental health problem recently were less optimistic about the role of close family or friends and professional help, perhaps due to recent distress. This outcome further supports the need for improved mental health literacy among young people which will aid timely diagnosis and intervention for various mental health problems. In addition, in a research report examining both of the above samples, Yap et al. (2012b) added that although young people expressed awareness and intention to take supportive actions, the value of encouraging professional treatment for mental health disorder was not universally recognised.

4.1.1.3. Belief in dealing with depression alone

In another survey by Jorm et al. (2006) conducted in Australia data was drawn from a school survey among 552 students aged 14-16 and a survey of 557 young people aged 12-17 for a comparison with adult data. They examined socio-demographic characteristics, recognition of depression, contact with people with depression and beliefs about use of substances, causes, treatments and long-term outcomes. Findings suggested that those who believed in dealing with depression alone were less likely to recognise the condition correctly. They also were significantly less likely to endorse counselling, psychiatrists, peer group therapy or relaxation courses. The group who believed in dealing with depression alone were more likely to endorse help from naturopaths, pharmacists and special diet. They were also less likely to endorse help from GPs and social workers and more likely to view alcohol and substances as helpful. This group also were more pessimistic about the benefits of treatment and believed in a recovery without treatment.

Significant gender differences were observed with male adolescents more likely to view dealing with depression alone as helpful. Male adolescents who believed in dealing with depression alone were more likely to favour help from a friend, a trend not observed among female adolescents. This is in line with the findings of an earlier Australian study by Rickwood and Braithwaite (1994). They reported that in a sample of 715 adolescents, 27 % were moderately to severely distressed. Of these adolescents 23% sought no help at all and only 17% sought professional help. There were no gender differences in the levels of distress, but there was a marked difference in help-seeking behaviour. Male adolescents with even high levels of distress did not seek help from their social circles or from professionals. Help-seeking was predicted by psychological distress, being female, availability of social support, knowing someone who had sought or received professional help, and willingness to disclose mental health. When the group with evident emotional distress was considered, gender and willingness to disclose remained significant predictors. Psychological symptoms and gender were shown to be more relevant predictors of the behavioural measure of help-seeking than social support or personality characteristics. These gender differences were also observed in Moller-Leimkuhler (2001) who emphasised on the importance of male gender expectations. Male gender role, she argued, was characterised by striving for power, dominance, independence, rationality, success, invulnerability and control. Thus gender-related health concepts led to undervaluation and denial of symptoms in young males. Aiming for success might bring social appreciation to male gender, but it also puts the individual under pressure to meet expectations and behave in a certain way (e.g. suppressing stress which is viewed as incompatible with traditional masculinity attributes). Adolescent males responded to emotional problems with stoicism and heightened threshold for emotional sensitivity and pain expression. Gender stereotypes could be defined as substantial obstacle to help-seeking as they often lead to under diagnosis and under treatment of depression. Male

adolescents refrained from help-seeking for depression even when such help was really needed and was available to them.

4.1.1.4. Help -seeking behaviour in adolescents – barriers and the role of stigma

Despite the importance of adolescence as a life period, many young people, mainly due to lack of knowledge and various misconstructions, refuse to seek help or postpone help seeking due to various reasons such as: fear of stigma associated with mental health problems (when it is seen as a weakness); concerns about anonymity and confidentiality issues; insufficient knowledge about the availability of help or the common misconception that, within adolescence, the signs and symptoms indicate only a temporary age crisis. Stigma, by definition, is "a mark of disgrace that sets a person apart. When a person is labelled by their illness they are seen as part of a stereotyped group. Negative attitudes create prejudice which leads to negative actions and discrimination."(Australian Mental Health Commission). Goffman (1963) argued that stigma reflects a negative social attitude toward mental illness. It is characterised by discrepancy between a person's 'virtual social identity' (what the society thinks of a particular person) and their 'actual social identity'(the real attributes possessed by any individual). Further, he believed that stigma highlighted discrediting traits and could lead to negative assumptions about the person's character and result in forms of discrimination.

Stigma in combination with a lack of appropriate responses from both peers and adults (often because they don't have the knowledge about the condition, the problems were allowed to worsen without an appropriate intervention (Barker et al., 2005). Their findings suggested that there were individual and structural determinants of young people's help-seeking behaviour. Several factors influenced the demand for help: policy, social support and specific health problems and needs. Barker et al. (2005) emphasised

that trust, reconsideration of adult attitudes toward young people, and reducing the stigma associated with seeking help are paramount to promoting help-seeking behaviour. Many adolescents were not offered help because of social exclusion, violence, poverty, prejudice and gender inequalities. All of these obstacles can be traced to limited mental health literacy (Loureiro, 2015). The consequent lack of help seeking or delay in help seeking led to worse health outcomes and chronicity.

These results are further supported by Thompson et al. (2008) who investigated the significance of the initial delay to first seeking of professional help. Help-seeking history was retrospectively reported by 273 new referrals to a specialist treatment clinic.22% had a primary diagnosis of mood disorder. Various demographic, social, clinical, and attitudinal variables were tested as eventual predictors of length of the delay. Average help-seeking delay was 8.2 years throughout life but younger age at symptom onset and slower problem recognition were the main contributors to delayed help-seeking.

Gasquet et al. (1997) acknowledged additional factors influencing adolescent seeking consultation for depression. In a study of 3,287 French students aged 12-20 years, different factors related to medical help were examined. 14.4% of the sample have sought professional help for depression. Among the group with the same depressive level, females, older adolescents, adolescents with separated parents, problems in school or with health problems, more often sought help for depression. Socio economic status was not found to play a role in seeking help for depression. Most often, adolescents got help from general practitioners and school nurses. Non-medical professionals also contributed to the initial assessment for medical help for depression. A low number (8.4%) of the respondents who consulted for depression initially, turned to specific mental health services.

A more recent study by Raviv (2010) is in line with these findings. 662 Israeli adolescents in the 10th and 12th grades were asked to read a vignette and say which help sources (friend and psychologist) they would refer the teenager from the scenario. They were also asked the same questions in reference to themselves, imagining that they were experiencing the same problems. Results showed that adolescents were able to identify the severity of emotional disturbance and recognize the need for psychological help in the individual from the vignette. Despite these findings and a generally positive attitude toward psychological help (assessed through a supplementary scale), there was a significant gap between the respondents' willingness to refer a distressed peer for help as opposed to themselves. Boldero and Fallon (1995) examined a group of 1013 school-aged adolescents. They were asked to identify a problem which had caused them considerable distress during the last 6 months. Additionally, information about the problem and type of help (if sought) was collected plus information regarding the seriousness and stigma related to their problems. Four major factors were identified: health issues, education, family and interpersonal relationships. Friends and family were the preferred people to turn to, closely followed by teachers. Help-seeking behaviour was found to be predicted by problem type and gender and choice of the help sources was associated with all four factors.

In a study of over 9000 USA adolescents, Sen (2004) investigated whether respondents have suffered from depressed mood over the previous year and if they sought help and from whom. Gender and ethnicity differences were explored. Non-Hispanic whites, non-Hispanic blacks, Hispanics and Asians took part in the study and their help-seeking behaviour patterns were recorded. The results also indicated that adolescent females were significantly more likely than adolescent males to suffer from depressed mood and more likely to seek help for it. Minority groups were more likely to suffer from depressed

mood compared to non-Hispanic whites, but Blacks and Asians were especially reluctant to ask for help, particularly the male adolescents.

Cultural differences related to stigma in help-seeking were also observed by Yang et.al (2014). Chinese respondents valued control of emotion and moral cultivation. Mental illness was viewed as a "threat" to these traditional values. Among the Latin-American community, who value hard-working and being "tough" in the face of problems, a common attitude was that many mental health problems can be treated with individual will. Mental illness was indicative of laziness. This group valued coping with stressors without psychiatric medication and they viewed antidepressants as addictive opposing their use. African-Americans, on the other hand, were hesitant in disclosing any emotions and thoughts of private character and distrusted mental health professionals.

The cultural aspect of stigma was also acknowledged in a study by Lauber and Rossler (2007) who examined its aspects in several developing countries. Comparable to Western countries, those with mental illness were stigmatised and discriminated. People with mental health problems were viewed as aggressive or dangerous – a clear prerequisite for social distance. The authors acknowledged the role of supernatural, religious and magical approaches to mental illness which were widespread. People were sceptic towards mental health treatment. Stigma experienced from family members was also prevalent, so were social disapproval towards the families of people with mental health problems.

4.1.2. Mental health literacy in Adults

4.1.2.1. Adult recognition of Depression

Research evidence suggests that poor recognition of depression is not only an adolescent problem. Jorm et al. (1997) examined 2031 respondents aged 18-74 years in Australia, 1010 participants were questioned about the depression vignette and 1021 about the

schizophrenia vignette. 72% of the individuals questioned about depression recognised the presence of some psychological disorder but only 39% were able to label the condition correctly.

In the same study different sources of help were rated for depression with general practitioners (83%) and counsellors (74%) were most often rated as helpful whereas psychiatrists (51%) and psychologists (49%) less so. Standard psychiatric treatments (antidepressants, neuroleptics, antipsychotics, admission to a psychiatric ward) were rated as harmful and some non-standard treatments were rated as helpful (increased physical or social activity, stress management, getting more information about the condition, vitamins and special diet).

In a British general population survey by Swami (2012), 1,218 adults aged 18-78 years were tested for their ability to recognise depression. Other measures such as attitudes toward seeking psychological help, psychiatric scepticism, and anti-scientific views were also recorded. Some respondents answered questions about a male target with symptoms of depression, others about a female one. For the female vignette, 56.8% of respondents said she did, 10.1% said she did not, and 33.1% were unsure. Of those who thought she did, the most frequent answer was ‘depression’ (77.1%). For the male vignette, 52.0% of participants indicated that the target had a mental health disorder, 20.8% said he did not, and 27.2% were unsure. If they thought he did have a disorder, ‘depression’ was the most common follow-up answer (84.4%). Participants were more likely to think that the male vignette did not suffer from a disorder compared to the female vignette. Respondents’ gender did not have an impact with regards to female vignette scenario, but men were more likely than women to think that the male vignette did not have a disorder. Deen and Bridges (2011) have found that recognition rates for depression were low among adults from rural backgrounds. In a rural American sample only 53% of the sample had high

mental health literacy and men had significantly lower depression literacy than women (35% vs 68%). Even after controlling for demographic and symptom variables, the effect was evident. Depression literacy did not significantly predict perceived need for a doctor, counsellor, or religious leader, but it did significantly predict utilization of a religious leader, indicating various cultural understandings of depression.

Results from different countries highlighted a similar problem. In a Swedish community study by Dahlberg et al. (2008), 3538 participants aged 20-64 years were assessed on a depression vignette. Two thirds of participants failed to recognize depression and the rates were equally poor in mentally healthy people and in persons with symptoms of mental illness (regardless of contact with mental health professional). A third of respondents suggested counselling as appropriate treatment and only 1% proposed antidepressant treatment. People who had contact with a health professional more often suggested that a GP would be able to offer appropriate help. This group was also more positive towards medical interventions (antidepressants, hypnotics, and in-patient treatment) and less likely to believe in full recovery without such intervention. The group without medical contact were more optimistic and believed recovery was possible without intervention. In this study individual medical history was the most prominent predictor for depression recognition and beliefs about treatment.

Experiencing depression as a factor influencing mental health literacy was examined by Goldney et al. (2001). 3010 respondents from a random sample answered questions about a vignette of a person with features of major depression. Results indicated that those with major depression had significantly more personal experience of depression than those with less severe depression and those who were not depressed. With regards to mental health literacy, differences between these groups were not significant. Respondents with

major depression were hesitant in their views about antidepressants - 40% considered anti-depressants helpful but 40% also thought they were harmful.

4.1.2.2. Beliefs about helpfulness of actions and treatments

In a comparative study of two completely different cultures with major differences in healthcare, Australia and Japan, Jorm et al. (2005) presented respondents from each country with one of four case vignettes: depression, depression with suicidal thoughts, early schizophrenia or chronic schizophrenia. In Australia, the survey involved a national sample of 3998 adults aged 18 years or over. In Japan, the survey involved 2000 adults aged 20-69 years. In Australia, "depression" was the term used most often to describe the depression vignette and the depression with suicidal thoughts vignette. In Japan, there wasn't a prevalent term describing the depression vignettes - "depression", "stress" and "psychological/ emotional problems" were the most common terms. In Australia, 50% of respondents considered seeing a GP for the depression vignettes, counsellor or talking to friends and family. In Japan, the most common answers for the depression vignettes were counselling and family/ friends. In neither country there was a high level of endorsement for some standard psychiatric interventions such as antidepressants or psychotherapy for the depression vignettes.

Belief about effectiveness of different treatments were also assessed in a study by Jorm et al. (2000). 3109 Australian adults were questioned regarding beliefs about the helpfulness of different interventions for depression. Their level of anxiety and depression symptoms and history of treated depression where applicable were also recorded. 422 people with elevated symptoms level took part in a follow-up study after six months by giving information on the interventions they had used. By comparing results it was possible to assess whether beliefs and other factors in the beginning predicted subsequent use of various interventions. Some of the interventions were rated as likely to be helpful initially

but this rating did not affect their subsequent use (e.g. mental health professionals were rated as likely to be helpful, but were rarely used in cases of eventual symptoms). On the other hand, more accessible and low cots interventions were used more frequently, but were not the most likely to be viewed as helpful (e.g. physical activity). History of treatment, present symptoms, gender and belief in a particular intervention were the most significant predictors for subsequent behaviour. An interesting finding was that beliefs in the helpfulness of antidepressants predicted their use at a later stage.

However, such effect was not observed in sample of 1387 American adults by Croghan et al. (2003). The role of attitudes regarding the effectiveness of and potential problems associated with psychiatric medications and the respondents' willingness to use them were examined. Results indicated that psychiatric medications were generally considered effective, because fewer than half of the participants expressed any concerns regarding potential problems but at the same time were not willing to use them. Current health status and past history of mental health treatments were contributing factors.

Adult respondents in a British study of attitudes to treatments of depression by Priest et al. (1996) also expressed unwillingness to use antidepressants. 2003 participants were interviewed. Although the majority seemed to be sympathetic to those with depression, they were reluctant to seek professional help, therefore projecting their prejudices onto the medical profession. 1704 respondents (85%) believed counselling to be effective but were against antidepressants. 1563 respondents (78%) considered antidepressants as addictive. Only 16% believed that antidepressants should be administered to depressed people. Due to this negative attitude and a fear of addiction a lot of depressed people in primary care abandon taking them prematurely.

Attitudes to causes and treatment options for mental illness were also investigated in a South African sample. Hugo et al. (2003) assessed the attitudes of 667 adult participants

by giving them eight vignettes, portraying depression, schizophrenia, panic disorder or substance abuse, with subtle or obvious symptoms.

Results indicated that respondents viewed scenarios as stress-related or attributed problems to a lack of willpower but not real medical disorders. Consulting professional help was not a common choice, many respondents opted for talking over the condition. In cases of substance abuse and in those with subtle symptom presentation, psychotherapy was viewed as the most appropriate treatment. Again, preferences for treatment and help-seeking behaviour were heavily influenced by misinformation and the role of stigma.

4.1.2.3. Belief in dealing with depression alone

Psychological research among adults often indicates that many are unwilling to seek professional help and believe in other measures, including dealing with the condition alone. Jorm et al. (2006) collected data from 1001 Australian adults for comparison with adolescent data. 13.2% believed it would be helpful to deal with the condition alone (14.8% of male respondents and 11.7 % of female respondents). 63.4 % believed it would be harmful to deal with depression alone (56.8% male and 69.6% female).

The group who believed in dealing with depression alone was significantly less likely to recognise the condition correctly from the vignette (helpful 53.6 %, harmful 68.0 %). This group were also less likely to recognise the symptoms in a friend or relative as significantly fewer respondents from this group reported that someone close to them had the condition (helpful 41.7 %, harmful 55.4%). Respondents who believed in dealing with depression alone were less likely to endorse help from GPs and psychiatrists, relying on close family/friends and alcohol to feel better. This group also expressed scepticism about full recovery after treatment (helpful 74.6 %, harmful

82.7%) whilst believing recovery was possible without it (helpful 54.2 %, harmful 71.0 %).

Another significant difference was observed with regards to belief about the cause. The group who believed in dealing with depression alone more often reported character weakness as a cause (helpful 53.4 %, harmful 39.7%).

In a survey of 2000 Australian adults, Griffiths et al. (2011) sought to explore the preference for self-reliance as opposed to seeking professional assistance in people with depressive disorders. Participants were shown one of two scenarios: vignette describing depression (n=1001) or a vignette describing depression with suicidal tendencies (n=999). Respondents were asked if they thought it would be helpful/harmful to deal with the presented condition alone. Results indicated that personal stigma was the main predictor of the belief in dealing with depression alone. Self-reliance in respondents could be traced to and attributed to high levels of personal or self- stigma (people's own responses to depression and help-seeking) and lower levels of perceived stigma (perception of other people's negative responses).

3.4.3. Help-seeking behaviour – barriers and the role of stigma

Stigma related to help-seeking for depression was investigated in a study by Barney et al. (2006). 1312 Australian adults selected randomly answered question about a depression vignette. Self and perceived-stigma and help-seeking intentions were recorded. Respondents disclosed unwillingness to seek professional help and believed that other people or the professionals themselves would react negatively towards them if they sought help.

Another study by Barney et al. (2009) added more aspects to help-seeking and stigma. Focus group discussions with 23 adults with history of depression were thematically

analysed. Results indicated that respondents usually think that others believe depressed people are responsible for their own condition, are undesirable to be around and are dangerous. Participants were particularly unwilling to seek help in the workplace and from mental health professionals. A common view expressed by participants was that depression could be concealed in order to avoid negative responses from others. Respondents believed that other often underrate the condition and see it as a sadness which shortly resolves on its own. An interesting finding regarding the underestimation/overestimation of difficulties associated with depression was observed. Some believed that the majority of people did not know how difficult it was to live with depression, whereas others thought that concerns were overestimated, especially in the workplace where depressed people were viewed as unable to keep up with work duties. Another reflection of stigma was the social distancing - participants reported that others do not want to be around depressed people because of the negativity associated with the condition. A common view held by the respondents was that others believed the condition was fully under their control and they could regulate it if they wanted to. With regards to informal help-seeking, respondents (especially male respondents) were unwilling to seek help from friends or work colleagues because of fears associated with stigma. Seeking help from mental health professionals, especially psychiatrists was viewed as undesirable, particularly in males (Seeking help from GP was associated with less stigma). Participants also wanted to hide the use of antidepressants from others, fearing a negative reaction.

Experiences of adults' whose lives were affected by depression, particularly their interaction with the healthcare system and barriers in help-seeking were explored in a study by McNair et al. (2002). They collected data from 21 community meetings (1529 people, 911 evaluation forms were provided) and nine focus groups (69 individuals) held across Australia. Common themes regarding healthcare included: difficulty

accessing family doctors with time, skill or commitment to mental health services; difficulty accessing special mental healthcare; difficulties related to access to reliable information about the condition, lack of effective responses of healthcare services to problematic situations, lack of continuity of treatment or coordination of medical and psychological dimensions, lack of coordination of medical and psychological aspects of care, financial cost of special care and excessive medicalisation of treatment for depression. Social distancing was attributed to stigma associated with depression or anxiety, discrimination in the workplace and family issues related to the unwillingness to accept that a family member has depression. Families and friends often did not believe or understand that depression is a serious illness. Instead they viewed it as normal self-correcting sadness which often prevented the establishment of supportive environment around.

The results of a study of 46 patients with mental health problems from North London by Dinos et al. (2004) are in line with these findings. Stigma was a prevalent issue to almost all participants. People with depression, anxiety and personality disorders often had to face patronising attitudes and feelings of stigma even if they had not experienced any overt discrimination. Stigma affected diagnosis, treatment and the way people view themselves.

Van Voorhes et al. (2005) also explored in what ways attitudes and beliefs about depression may prevent adults from accepting a diagnosis and treatment for depression. In a cross-sectional study of 10 962 participants, attitudes and beliefs toward treatment were examined and respondents were asked if they would accept their physician's diagnosis of depression. 26% of the participants stated their intent not to accept their physician's diagnosis of depression. Disagreeing that medications are effective in treating depression, believing that there is a biological cause for depression and stating

that you would be embarrassed if your friends knew you had depression were associated with the intent not to accept a diagnosis of depression, thus leading to low rates of subsequent treatment.

The importance of stigma in relation to help-seeking intentions and behaviour was also evaluated in a recent study by Reynders et al. (2014).They compared data of 2999 Dutch and Flemish respondents aged 18-65 years and argued that access to appropriate mental healthcare was necessary but such services were not always available or accessible. Stigma was the factor most often related to help seeking intentions. Cross-national differences between respondents were related to professional and informal help seeking intentions in low and high suicide rate regions. Their perceived and self-stigma together with shame and intention to seek help were assessed. People in the Netherlands, where suicide rates are low, expressed more positive attitudes toward help seeking and experienced less self-stigma and shame compared to the people in Flanders, where suicide rates are high. The differences applied to formal and informal help-seeking intentions. Perceived stigma was negatively associated with informal help seeking, whereas shame was positively associated with higher intention to use psychotropic drugs. Perceived stigma, on the other hand, was negatively associated with formal help-seeking intention in Flanders but not in the Netherlands, highlighting the importance of the promotion of positive attitudes and the reduction of stigma in order to facilitate help-seeking in both formal and informal aspects.

4.1.3. Summary of literature review

The above presented research background for adolescents and adults offers an important insight into the problems facing both groups with regards to the recognition, beliefs, intentions, help-seeking behaviour, barriers and the role of stigma related to depression. Both groups usually tended underestimate the condition as a temporary self-resolving

issue, not realising its seriousness and the possibility of chronicity. Evidence indicated that adolescents were at risk particularly because of their insufficient knowledge of depression and limited life experience, combined with the willingness to follow certain gender models. They were particularly vulnerable as they relied mostly on others around them to recognise depression symptoms and to offer adequate formal/informal help. Adults, on the other hand, despite generally showing better results for mental health literacy, were more affected by stigma and unwilling to admit problems with depression to family, friends or in their workplace.

However, almost all of these studies were conducted in Western countries where people share similar values and beliefs. It is not known if similar results will be obtained in Bulgaria, so this study will explore mental health literacy in Bulgarian adolescents and adults.

4.2. Study aim

The aim of the present study was mainly five-fold: a) to what extend the Bulgarian adolescent and adults are able to identify depression, b) is there any gender difference in adolescent and adult sample in terms of ability to accurately label depression, c) is there any difference between the adolescent and adult samples in terms of treatments suggested for those with depression, d) is there any difference between the adolescent and adults in terms of activities or behavior suggested to prevent depression, e) is there any difference between the adolescent and adults in terms of the causes indicated for depression.

4.3. Method

4.3.1. Participants and procedure

Data for the present study derived from two sample of community in Bulgaria. Both samples completed a short survey on Mental Health Literacy based on Jorm et al. (1997) containing a vignette scenario with the description of a depressed person of a similar age to respondents. They were asked a number of questions about the person – some of them related to the ability to recognise the condition, others covered beliefs about treatment and stigma in help-seeking.

The first sample of the study consisted of 700 adolescents (53.9% were boys and 46.1% were girls) who have been recruited from urban and suburban schools in Veliko Tarnovo city region in Bulgaria. They ranged in age from 13 to 17 years (M = 15.31, SD = 1.2). Most of the adolescents reported their religious affiliation as Christian (83.6%), 6.4% were Islam, 0.1% Judaism, 0.1% Buddhism, and 9.7% reported that they were not affiliated with any religious organizations. Almost all of them were Caucasian (93.7%); 1.3% were Roma and 5% were Turkish or other ethnic groups.

The second sample included 250 (107 men, 143 women) adults. The mean age of the second sample was 44.78 (SD = 6.49) with an age ranged between 35 and 58. Most participants reported they were married (75%) with equivalent of A level of education (44.4). Most of the adults reported their religious affiliation as Christian (90.2%), 4% were Islam, and 5.2% reported that they were not affiliated with any religious organizations. Almost all of them were Caucasian (99.6%).

4.3.2. Measures

Mental Health Literacy Questionnaire (MHLQ; Jorm et al.,1997) was used to assess the participants understanding depression. It first provides a vignette portraying a person with depression, and then lists a variety of possible questions regarding recognizing depression and strategies to be helpful for the depression. The age of the person portraying in the vignette was identified in terms of the sample used (adolescents vs. adults). The vignette

used for the adolescent group was:

> "John is a 15 years old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him."

The vignette used for the adult group was:

> "John is a 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making any decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity"

In following five parts of the MHLQ, the participants were assessed in terms of the reply for each part.

In the *first* part of MHLQ, *Recognition of depression*, the participants' knowledge and recognition of the disorder shown in the vignette were assessed by asking the following open-ended question: "What, if anything, do you think is wrong with John?" The correct answer was "depression". Participants' responses were classified as "other", where their responses were not depression. Other responses were examined and coded into five categories including psychological problems (e.g., worried, anxious), love

problems (e.g., breaking up, conflict), behavior related to puberty, sick, and I don't know.

In the second part, *beliefs about types of help*, the participants were assessed by a series of questions in terms of the interventions covered a wide range of professionals (GP or family doctor, teacher, counsellor, telephone counsellor, psychologist, psychiatrist, other mental health professional, close family member, close friend, on his own), medications (i.e., vitamins, St John's Wort, antidepressants, tranquillizers, antipsychotics, sleeping pills). The respondents were asked to indicate the likely helpfulness of the interventions by rating as "helpful", "harmful" or "neither" for the person in the vignette.

For the third part, *beliefs about socializing with him* were asked by the following question: "How would you feel about spending time with John. Would you be happy if you…?" The actions that followed were: go out with him on the weekend, work on a project with John, invite him around your house, go to his house, to develop a close friendship with him. Responses were coded as "yes definitely", "yes probably", "probably not", "definitely not", "don't know".

Fourth part included *Beliefs about likely causes of depression* and participants' knowledge were assessed by asking the participants to rate the likelihood of John's situation as caused by the following: bad character, brain disease or disorder, the way he was raised, stress, genetic or inherited problem, god's will, bad luck, normal ups-and-downs of life, mental illness, physical illness.

In the last part, *Exposure to depression* was assessed by asking participants whether they had a close friend of family member with a similar problem. Each item were rated by "yes", "no" or "don't know" response and included questions such as "Has anyone in

your family or close circle of friends ever had a problem similar to John's?''

The MHLQ was developed and used extensively with English speaking participants, thereby needing to be translated and adapted for administration to Bulgarian population. Hence, a bilingual translator who was also a native speaker and culturally aware blindly translated the scale from English to Bulgarian. The translated scale was then given to an English literature expert to translate the Bulgarian version of Mental Health Literacy Questionnaire items back into English. Then back-translated items were given to experienced clinical psychologists to establish the content equivalence of the Bulgarian version of the scale. Differences in the original and the back-translated versions were discussed and resolved by joint agreement of the experts and the researchers.

4.3.3. Statistical Analysis

Data were pooled across adolescents and adult versions of the vignettes for analysis. Group of respondents was classified into two groups as adolescent and adults along with their gender differences and cross tabulated with the variables of interest. Percentages were calculated using cross tabulations in SPSS 19.0. Response categories with frequencies of less than 2% for both vignettes were omitted from the analysis. Z-tests were used to assess differences between adolescent and adult groups, with a significance level set at $p < .001$. Effect sizes (Cohen's *h*) were calculated for each proportion differences using the formula from Cooper and Hedges (1994). An effect size of $h = 0.20$ was considered small, $h = 0.50$ medium, and $h = 0.80$ large, according to the interpretive guideline for effect sizes by Cohen (1992). Only significant group differences with a 'medium' effect size equivalent to Cohen's $h = 0.5$ are discussed.

4.4. Results

4.4.1. Analysis of variables

Recognition of Depression

Table 4.1 presents coded responses to the open-ended question "What, if anything, do you think is wrong with John?" in terms of the gender and age (adolescents vs. adults). In adolescent group 64 participants responded as "don't know" and most of the adolescents (220) answered as "Psychological problems". "Sick" was not the common response reported by adolescents (13.7% of all the participants); the least common response was "depression" (8.0%). In adult group, on the other hand, 33.6 % of the adults responded as "psychological problem" and the following common response was "depression" (28.4 %, 71 adults). The least common response (18) was "behavior problem". Adults were significantly better at recognizing depression than adolescents (z = 6.72, h=.12); whereas, adolescents were more likely to suggest that the person in the vignette had "love problems" (z = 3.73, h=.16), compared with the adults. The adolescents were also more likely to indicate that the person described in the vignette was having "behaviour related to puberty" (z = 4.56, h=.10).

Table 4.1 Percentages of respondents endorsing each category to describe the problem shown in the vignette

	Adolescents				Adults		
	Boys (N=377)	Girls (N= 323)	Total (N = 700)		Men (N= 107)	Women (N=143)	Total((N = 250)
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)
Depression	20 (5.3)	36 (11.1)	**56 (8.0)**		25 (23.4)	46 (32.2)	**71 (8.4)**

Psychological problems	97 (25.7)	123 (38.1)	220 (31.4)		32 (35.5)	46 (32.2)	84 (33.6)
Sick	72 (19.1)	24 (7.4)	96 (13.7)		14 (13.1)	11 (7.7)	25 (10.0)
Love Problems	77 (20.4)	67 (20.7)	**144 (20.6)**		7 (6.5)	21 (14.7)	**28 (11.2)**
Behavior related to puberty	66 (17.5)	54 (16.7)	**120 (17.1)**		9 (8.4)	9 (6.3)	**18 (7.2)**
I don't know	45 (11.9)	19 (5.9)	64 (9.1)		14 (13.1)	10 (7.0)	24 (9.6)

Results in bold indicate significant differences between adolescents and adults at $p < .05$ or less.

Beliefs about types of help and treatments

Table 4.2. shows the percentage of respondents who rated different people's help as "helpful" for the person described in the vignette. As for adolescents, among those people who might help John, "GP or the family doctor" was the most frequently identified (39.5 %), whereas "a telephone counseling service" was least frequently reported as helpful (22.3 %). In the adult group, "psychologist" was the most endorsed (33.6 %) help; whereas, telephone-counseling service (23.6 %) was the least selected as helpful. The adolescents were significantly more likely than adults (15 to 17 years old) to see "GP or family doctor" helpful ($z = 2.88$, $h=.14$). On the contrary, the adults

suggested significantly more than adolescents to see a "psychologist" helpful (z = 2.10, h=.14).

Table 4.2. Percentages of respondents naming different people's help as helpful for the person described in the vignette.

	Adolescents				Adults		
	Boys (N = 377)	Girls (N = 323)	Total(N = 700)		Men (N = 107)	Women (N = 143)	Total(N = 250)
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)
GP or family doctor	150 (39.9)	126 (39.0)	**276 (39.5)**		30 (28.0)	44 (30.8)	**74 (29.6)**
Teacher	122 (32.4)	96 (29.7)	218 (31.1)		26 (24.3)	36 (25.2)	62 (24.8)
Counsellor	96 (25.5)	84 (26.0)	180 (25.7)		28 (26.2)	31 (21.7)	59 (23.6)
Telephone counsellor	87 (23.1)	69 (21.4)	156 (22.3)		26 (24.3)	33 (24.1)	59 (23.6)
Psychologist	95 (25.2)	90 (27.9)	**185 (26.4)**		37 (34.6)	47 (32.9)	**84 (33.6)**
Psychiatrist	98 (26.0)	95 (29.4)	193 (27.6)		24 (22.4)	42 (29.4)	66 (26.4)

Other MH professional	88 (23.3)	70 (21.7)	158 (22.6)		34 (31.8)	36 (25.2)	70 (28.0)
Close family member	117 (31.0)	8 (24.1)	195 (22.9)		23 (21.5)	37 (25.9)	60 (24.0)
Close friend	105 (27.9)	81 (25.1)	186 (26.6)		30 (28.0)	34 (23.8)	64 (25.6)
On his own	121 (32.1)	71 (22.0)	192 (27.4)		37 (34.6)	32 (22.4)	69 (27.6)

Results in bold indicate significant differences between age groups and/or gender at $p < .05$ or less.

Table 4.3 shows percentages of respondents naming different medicines as helpful for the problem of the vignettes' characters. The type of medicine that the adolescent respondents considered as the most helpful was antipsychotics, which more than half of the participants identified (51.7%). In the adult groups, more than half of the adults endorsed antidepressants (58.8) would be helpful. The least responded answer for the adolescent group was tranquilizers (20.3 %) and St. John's Wort (17.6%) and tranquilizers (16.8 %) for the adults. Compared with the older adolescents, adults were significantly more likely to view vitamins (z = 1.96, h=.10), antidepressant (z = 2.77, h=.09) helpful for the problem of the vignette's character.

Table 4.3. Percentages of respondents naming different medicines as helpful for the person described in the vignette

	Adolescents				Adults		
	Boys (N=377)	Girls (N= 323)	Total (N = 700)		Men (N = 107)	Women (N = 143)	Total (N = 250)
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)
Vitamins	122 (32.4)	74 (22.9)	**196 (28.0)**		45 (42.1)	42 (29.4)	**87 (34.8)**
St John's wort	98 (26.0)	63 (19.5)	161 (23.0)		24 (22.4)	20 (14.0)	44 (17.6)
Antidepressant	158 (41.9)	183 (56.7)	**341 (48.7)**		56 (52.3)	91 (63.6)	**147 (58.8)**
Tranquillizers	71 (18.8)	71 (22.0)	142(20.3		22 (20.6)	20 (14.0)	42 (16.8)
Antipsychotics	175 (46.4)	187 (57.9)	362 (51.7)		64 (59.8)	78 (54.5)	142 (56.8)
Sleeping pills	125 (33.2)	88(27.2)	213 (30.4)		43 (40.2)	48 (33.6)	91 (36.4)

Results in bold indicate significant differences between age groups and/or gender at $p < .05$ or less.

Socializing

Table 4.4. shows percentages of respondents who rated socializing with the person in the vignette as “definitely”. Most of the adolescents (35.9 %) indicated definitely to “develop a close relationship” and 32.4 % of adults reported either to “work on a project” or “invite him around house”.

Any significant difference was found between adolescents’ and adults’ rating toward socializing.

Beliefs about likely causes

Table 4.5. shows percentages of respondents who rated various causes of depression as either “very likely” or “somewhat likely”. The most frequently endorsed cause by both groups was “stress” (49.0 % of adolescents and 63.2 % of adults), followed by “way of raising” (40.0%) by the adolescents and “the normal ups and down of the life” (42.8 %) by the adults. The least commonly identified causes were “physical illness” (10.6 %) and “God’s will” (11.1 %) in the group of adolescents. Similarly, the least indicated cause of depression by adults were “God’s will” (11.6 %) and “a physical illness” (12.0 %).

Adolescents compared to adults were more likely to identify “his own bad character” (z = 2.0, h=.11) and “stress” (z = 3.95, h=.11) as underlying causes of depression, whereas the adults were more likely than the adolescents to back “stress” (z = 3.95, h=.11), the “normal ups and downs of life” (z = 2.89, h=.11), “mental illness” (z = 3.82, h=.11) and “physical illness” (z = 1.99, h=.11) as likely causes.

Table 4.4 Percentages of respondents rating about definitely socializing with the person described in the vignette.

	Adolescents		Adults

	Boys (N=377)	Girls (N= 323)	Total (N = 700)		Men (N = 107)	Women (N= 143)	Total (N = 250)
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)
Go out weekend	139 (36.9)	86 (26.6)	225 (32.1)		36 (33.6)	37 (25.9)	73 (29.2)
Work on a project with him	126 (33.4)	76 (23.5)	202 (28.9)		36 (33.6)	45 (31.5)	81 (32.4)
Invite him around house	130 (34.5)	85 (26.3)	215 (30.7)		35 (32.7)	46 (32.2)	81 (32.4)
Go to his house	120 (31.8)	81 (25.1)	201 (28.7)		26 (24.3)	41 (28.7)	67 (26.6)
Develop a close relation	139 (36.9)	112 (34.7)	251 (35.9)		31 (29.0)	47 (32.9)	78 (31.2)

ship							

Results in bold indicate significant differences between age groups and/or gender at $p < .05$ or less.

Table 4.5. Percentages of respondents rating causes for the disorder described in the vignette as 'very likely' or 'somewhat likely'.

	Adolescents				Adults		
	Boys (N=377)	Girls (N= 323)	Total (N = 700)		Men (N = 107)	Women (N= 143)	Total (N = 250)
	N (%)	N (%)	N (%)		N (%)	N (%)	N (%)
His own bad character	113 (30.0)	115 (35.6)	**288 (32.6)**		34 (31.8)	31 (21.7)	**65 (26.0)**
A brain disease or disorder	87 (23.1)	66 (20.4)	153 (21.9)		24 (22.4)	32 (22.4)	56 (22.4)
The way he was raised	154 (40.8)	127 (39.3)	281 (40.1)		42 (39.3)	52 (36.4)	94 (37.6)
Stress	141 (37.4)	202 (62.5)	**343 (49.0)**		67 (62.6)	91 (63.6)	**158 (63.2)**

A genetic or inherited problem	97 (25.7)	95 (29.4)	192 (27.4)		34 (31.8)	47 (32.9)	81 (32.4)
God's will	89 (23.6)	75 (23.2)	164 (23.4)		24 (22.4)	26 (18.2)	50 (20.0)
Bad luck	114 (30.2)	79 (24.5)	193 (27.6)		34 (31.8)	46 (32.2)	80 (32.0)
The normal ups and downs of life	143 (37.9)	120 (37.2)	**263 (37.6)**		50 (46.7)	57 (39.9)	**107(42.8)**
A mental illness	64 (17.0)	84 (26.0)	**148 (21.1)**		32 (29.9)	53 (37.1)	**85 (34.0)**
A physical illness	88 (23.3)	94 (29.1)	**182 (26.0)**		40 (37.4)	42 (29.4)	**82 (32.8)**

Results in bold indicate significant differences between age groups and/or gender at $p < .05$ or less.

Exposure to depression

Adolescents and adults were compared in terms of their exposure to depression (i.e., experience of depression in a family member or a close friend and/or their own experience). Significantly more adults (31.6 %) than adolescents (16.4%) reported having been exposed to depression of a family member or close friend ($z = 4.65$, $h=.13$).

4.4.2. Graphic representations of variables between adolescents and adults who correctly recognized depression

Perceived helpfulness of different ways of offering help to someone with a mental health problem

The percentage endorsements of the perceived helpfulness (versus harmfulness) of different ways of assisting an individual with a mental health problem are displayed in Figures 4.1 and 4.2 for adults and adolescents, respectively.

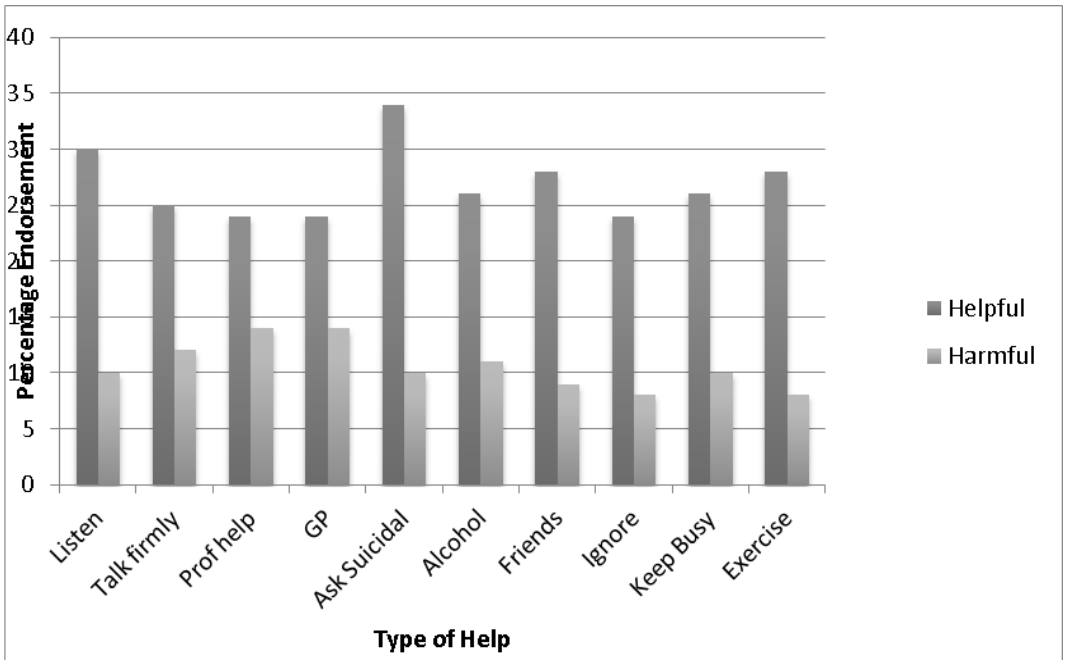


Figure 4.1. Percentage endorsements among Figure the adult sample of the helpfulness (versus harmfulness) of different ways of helping someone with a mental health problem

The percentage endorsements displayed in Figure 4.1 show that, among the adult sample, all potential ways of assisting an individual with a mental health problem were regarded as more helpful than harmful. The strategy perceived to be most helpful was 'ask if suicidal': 34% of adults believed that asking the person if they are suicidal would be a helpful strategy. Recommending that the individual seeks professional help,

referring them to their GP, and ignoring the person were regarded as the least helpful of the ten strategies (all endorsements = 24%). Interestingly, recommending to the individual that they seek professional help, and recommending that they seek help from their GP were regarded by adults as more harmful than all other ways of helping, including recommending that the individual have a few drinks to alleviate their problem.

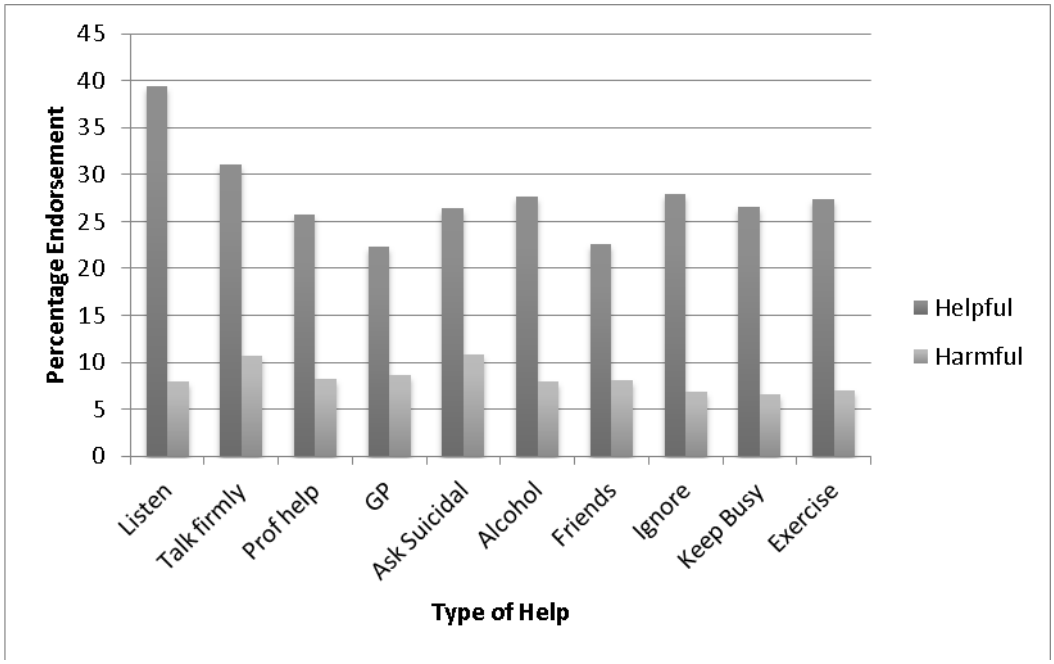


Figure 4.2. Percentage endorsements among the adolescent sample of the helpfulness (versus harmfulness) of different ways of helping someone with a mental health problem

The percentage endorsements displayed in Figure 4.2 show that, in common with the adult sample, adolescents regarded all potential ways of assisting an individual with a mental health problem as more helpful than harmful. Unlike the adult sample, however, the strategy perceived to be most helpful was 'listen': 39% of the adolescent sample perceived that listening to the individual's problems in an understanding way would be helpful for him. Interestingly, adolescents regarded GP referral as the least helpful strategy (22% endorsement). The most frequently endorsed 'harmful' strategies were asking the person if they are suicidal and talking to them firmly about 'getting their act

together' (both 11% endorsements). Interestingly, only 8% of the adolescent sample believed that it would be harmful to suggest to someone with a mental health problem that they have a few drinks to 'forget their troubles'; this was also the fourth most frequently endorsed 'helpful' strategy.

Perceived helpfulness of different sources of help for someone with a mental health problem

The percentage endorsements of the perceived helpfulness (versus harmfulness) of different sources of help for an individual with a mental health problem are displayed in Figures 4.3 and 4.4 for adults and adolescents, respectively.

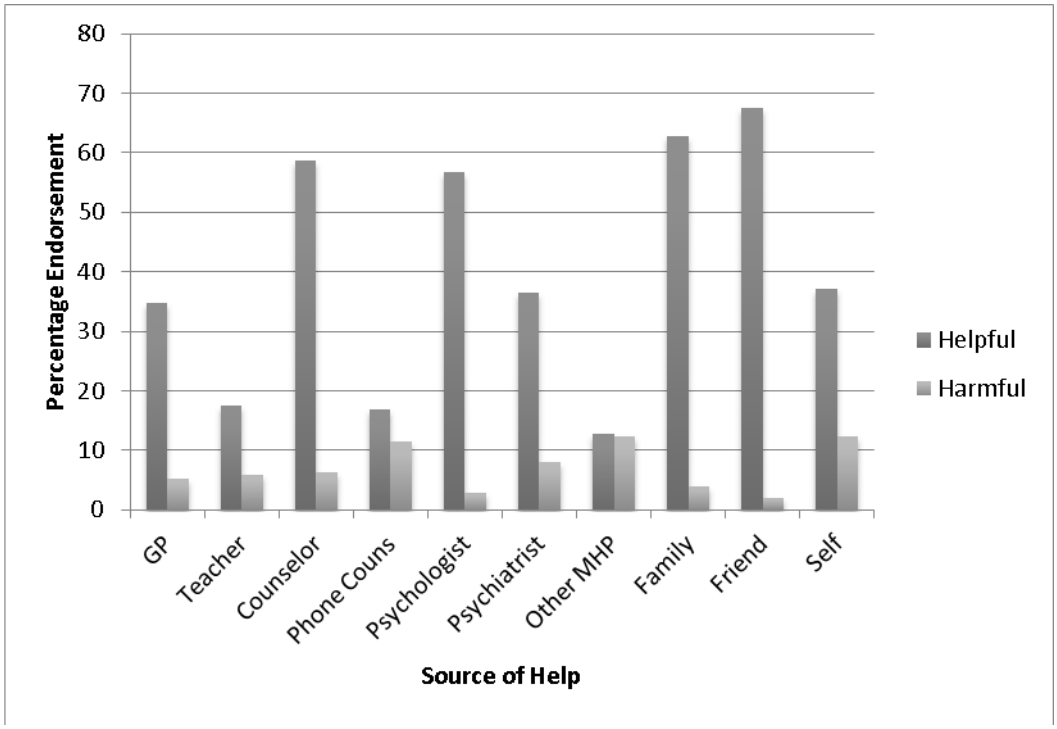


Figure 4.3. Percentage endorsements among the adult sample of the helpfulness (versus harmfulness) of different sources of help for someone with a mental health problem

The percentage endorsements in Figure 4.3. show that the source of help regarded as most helpful by adults was a close friend. Other mental health professionals, followed by phone counsellors, were regarded as the least helpful sources for the treatment of a

mental health problem. In fact, telephone counsellors, together with self-help, were regarded as the most harmful of all the different sources of help that adult respondents were questioned about. The percentage endorsements also indicate that adults perceived that the least harmful way of treating a mental health problem is by seeking help from a close friend (2% endorsement).

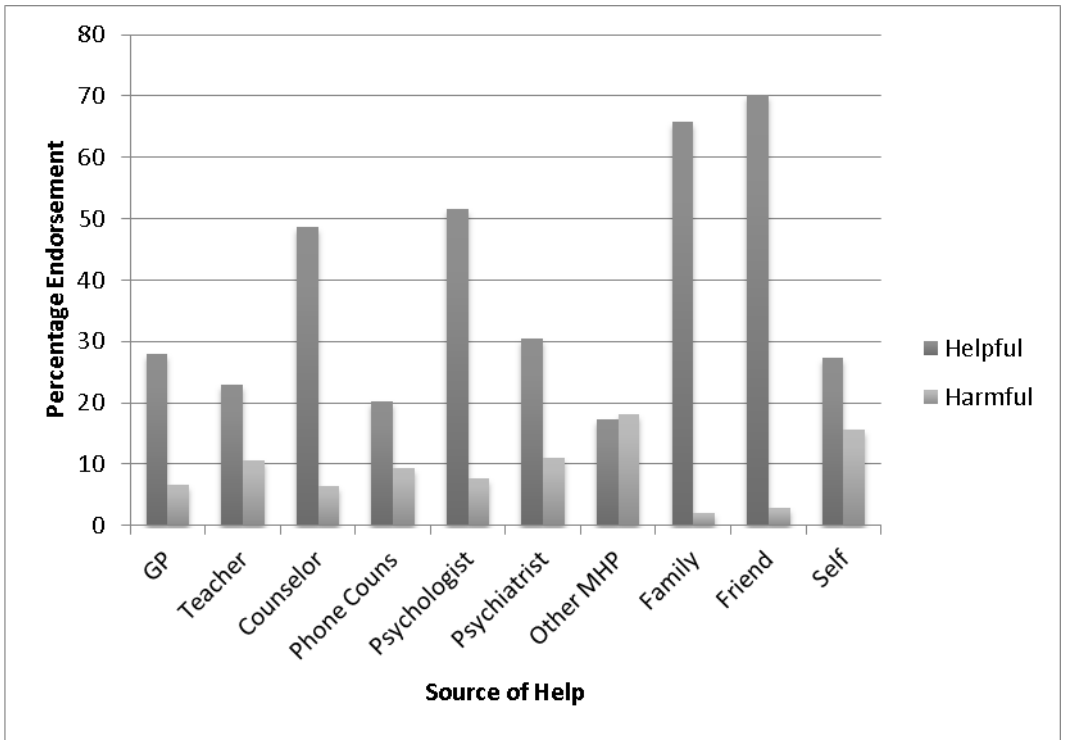


Figure 4.4. Percentage endorsements among the adolescent sample of the helpfulness (versus harmfulness) of different sources of help for someone with a mental health problem

The percentage endorsements displayed in Figure 4.4 show that the source of help that adolescents perceived as most helpful for the treatment of a mental health problem was a close friend; this was closely followed by a family member. These findings concerning the most helpful sources of help replicate those that were obtained among the adult sample. Among adolescents, the most frequently endorsed source of harm was other mental health professional: 18% of the sample believed that it would be harmful for someone with a mental health problem to be treated by a mental health professional such as a social worker or mental health nurse. This finding again replicates that

obtained among the adult sample. Again in common with the results obtained among the adult sample, more adolescents believed that it was harmful to receive treatment from a mental health professional than to deal with one's problem oneself.

4.5. Discussion

Results indicated that both adolescents and adults experience significant difficulties when they were asked to label the condition from the vignettes (depression) correctly. Only 8% of the adolescent sample were able to recognize depression correctly. This percentage of depression recognition is much lower than the results obtained from Western countries such as USA (Ollson and Kennedy, 2010), Australia (Wright et al., 2012) and Portugal (Loureiro et al., 2013). The results showed lower ability to recognize depression even compared to a Chinese sample (Lam, 2014). The percentage of adults who correctly labelled depression was 28.4%, significantly higher than the adolescent results, but still way lower than adult results from Western studies conducted in Australia (Jorm et. al, 1997), UK (Swami, 2012), USA (Deen and Bridges, 2011) and Sweden (Dahlberg et al., 2008). Several possible explanations could be found for these results: Firstly: Depression, even to this day, remains a western illness. "Depression-as-disease" is a Western model that usually does not apply well to non-Western cultures due to different viewpoints. People from non-Western cultures view "emotional problems" in situational and moral terms whereas the Western view these as internal, often biological and individual characteristics rather than situational (Lutz, 1985). These differences could explain the prevalence of answers such as "love problems" or "behaviour related to puberty" in our sample. Secondly, the ability to label depression correctly could be a direct result of depression prevention and treatment programmes. Research shows that these are very common in the West where such programmes get appropriate funding and media coverage, adding to their popularity and aiding

depression recognition. Examples include: LISA-T programme (Possel et al., 2004), RAP-Kiwi programme (Merry et al., 2004), Resourceful Adolescent Programme (Shochet, 2001) and Depression Prevention Program (Jaycox, 1994). To our knowledge, as of 2015, no similar programmes targeting adolescents or adults have taken place in Bulgaria. Thirdly, the overall health literacy (of which mental health literacy is an integral part) of the Bulgarian population is low to non-existent. In a recent research by Lefterova (2014), 50 % of undergraduate respondents declared that they have received no health education in school whatsoever, 30% were uncertain and only 20% could recollect receiving such education. Even to this day, health education is not a part of the Bulgarian national curriculum. Fourthly, adolescents could have poorer results than adults for depression recognition not only due to their lack of life experience, but also due to the fact that at this age they still rely on adults to make decisions about their health. Adults, on the other hand, are more competent because they do know the importance of making informed decisions about health issues and are much more likely to read more about illnesses and consider risks and benefits that come with these decisions (Halpern-Felsher and Cauffman, 2001).

There were significant differences between Bulgarian adolescents and adults in their beliefs about help-seeking. Adolescents trusted their GPs with 39.5 % of all respondents selecting this type of help over any other help for the depression scenario. Most preferred answer for the adults was “Psychologist” - 33.6 % of adult respondents chose this answer. Interestingly, these two formal types of help were chosen over informal types of help, such as family member or friend and no gender differences were observed for adolescents or adults. At first, these results seem in total disagreement with previous research for adolescents (Yap and Jorm, 2012, Cotton et al. (2006), Raviv et al., 2000) and adults (Jorm et al., 2005, Hugo et al., 2003) where informal help is preferred to formal and significant gender differences in help-seeking are observed. However, once

we take into consideration the really low depression recognition rates in our sample and perform frequency analyses only for the respondents who recognised depression correctly in both groups, the results look different. 76% of adults who correctly identified the problem in the vignette endorsed professional mental health service but none of the adolescents who correctly identified the problem in the vignette (0%) said that they would seek help from a service provider. 44% of adolescents said they would seek help from their mother. This is a very interesting finding that can be explored from a few viewpoints. In a study by Shonert-Reichl and Muller (1996), adolescent help-seeking for mental health problems from mother was attributed to internal locus of control. So, the adolescents who were likely to consider themselves independent and motivated by their own preferences, needs, rights, and the contracts they have established with others, giving priority to their own goals over the goals of others (Triandis, 1995) were much more likely to seek help from their mother. Internal locus of control, on the other hand, much like the condition of depression itself, is a predominantly Western concept found in developed, individualistic countries (Spector et al., 2002). This group of adolescents who appeared to follow this Western type of individualistic thinking were also the only ones who were able to label depression correctly. Jorm's questionnaire is a Western-derived measure of mental health literacy and it is possible that the vignette's contents resonate with people of particular mind set (and in the Bulgarian sample there are a very limited number of them). This view is supported by Summerfield (2006) who argued that mental and bodily state phenomena do not mean the same thing in different culture settings and therefore depression cannot be viewed as "… unitary, universally valid, pathological entity requiring medical intervention. " On the other hand, the fact that so many of the adults who recognised depression correctly endorsed professional help could mean that depression to them meant something different than to adolescents. A possible explanation could be found in

the Bulgarian transition from collectivist (Communism) to individualist society (Democracy) in less than one generation time. More adults recognised depression due to more life experience, having more control over their environment than adolescents and having the sole responsibility to look after one's own wellbeing (Stocks et al., 2012). However, the help-seeking intentions suggest a prevalent external locus of control for the adults related to collectivist thinking, a leftover from the Communist rule. This view is supported by Trompenaars and Hampden-Turner (1998) who found that much lower number of Bulgarian adults believed in being "captains of one's fate" than American adults.

It is interesting to note that although adults considered seeking professional help a helpful strategy, further analyses of the sub-sample who identified depression correctly showed that comparatively among both groups there were other more popular selections, related to informal help, such as "listening to the person" and "asking them if they are suicidal". These observations are in line with findings from other studies that emphasised the role of informal support (Barney et al, 2009, Jorm and Griffiths, 2006). However, an unexpected finding was the popularity of "having a few drinks" in order to help problems related to depression in both age groups – a strategy which was more popular with our participants than any form of professional help. For example, as low as 8% of adolescents thought it might have a harmful effect for depression. These results may have a cultural explanation. To a Westerner, such beliefs (particularly among the adolescents) might seem surprising. According to Popova et al. (2007) Bulgarian drinking culture for many years was wrongly considered equivalent to the culture of the former Soviet traditional vodka-drinking countries with mainly binge drinking patterns. She argued that Bulgarian style of drinking was similar to Mediterranean drinking culture – a much more relaxed, moderate and family-centred style, where people drank slowly, at home and with food rather than binge drink socially. Children are introduced

to alcohol early, usually over family gatherings and the prevalent views towards consuming alcohol in moderation were overwhelmingly positive. It is widely considered a relaxation instrument that makes people livelier, less tired and aids communication.

The differences between adolescents and adults samples were also observed with regards to their belief in helpfulness of different medicines. Significantly fewer adolescents believed in the helpfulness of vitamins and antidepressants for treatment of depression. After we performed analyses among the groups who identified depression correctly, the reasons for these differences became more evident. Adults believed antidepressants to be more helpful than harmful but more of them considered vitamins to be more helpful. Adolescents expressed negativism towards all of the prescription treatments. In addition, a significant number of adolescents believed that the reason for depression could be “his own bad character”, whereas adults were more likely to go for a more logical and likely reason such as “stress”. These differences can be attributed to the lower rate of recognition and exposure to depression among adolescents. 37% of adults and 9%of adolescents reported that a close relative or friend had had depression and a greater proportion of adults (25%) than adolescents (14%) reported that they had experienced depression themselves. Jorm et al. (2005) have found that adults viewed medical interventions positively when they were better educated or had an experience of depression (themselves or someone close to them).

4.5.1. Limitations

The study relied on self-report measures. Although they are most frequently used to measure psychological constructs, their disadvantages are also evident. Self-report measures rely on the presumptions that individuals have enough self-knowledge and they are willing to share it with the researcher which is not always true. According to Paulhus (1991), people often respond in a way that presents them in what they consider to be a

more favourable light, even if this is not how they usually think or behave (Socially Desirable Responding). “Extreme responding” or the tendency to give extreme ratings on self-report measures is also frequently observed and is difficult to address. (Paulhus and Vazire, 2007) In the future, a combination of self-report measures and observational methods can be used to obtain objective data.

Jorm’s questionnaire is a Western measure that has been translated to Bulgarian and back-translated to English. There is always a risk that translation might change some aspects of the original meaning. In addition, Western concepts are not always transferable and understandable in other countries due to different cultures and experiences

Data was collected from only one region of Bulgaria. Although a fair mixture of rural and urban respondents were recruited, the results could be different if data was collected from other regions of the country or in the capital.

4.5.2. Directions for future research

A future direction for research could seek to recruit more participants from different regions (agricultural, industrial, etc.) and compare data. This mental health literacy questionnaire is a quantitative measure. It provides statistical scores that make comparisons between groups easier but they give little information about unique, personal experiences for adolescents and adults. Qualitative studies with individual respondents (interviews, case studies, focus groups) can give a different perspective and help understand mental health literacy better.

CHAPTER 5: EXPERIENCING ANXIETY: A QUALITATIVE STUDY OF BULGARIAN ADOLESCENTS AND ADULTS (STUDY 3)

Research questions:

- What additional aspects of anxiety can be identified in Bulgarian adolescents and adults using qualitative measures?
- Can these aspects help to see the 'bigger picture' by adding new dimensions to the quantitative studies?

5.1. Overview

Study 1 and Study 2 have identified some important aspects of anxiety and depression among Bulgarian adolescents and adults. After exploring the prevalence, correlates and comorbidity of anxiety and depression combined with mental health literacy specificities in both age groups, a few consistent findings emerged: adolescent and adults scored differently for various sub-types of anxiety, self-construals and social support. They also showed marked gender and age differences in their anxiety prevalence and mental health literacy about depression. In order to understand these findings better, this qualitative study was developed. Its main purpose is to explore in depth what it is like to experience anxiety from adolescent and adult point of view.

5.2. Introduction

The measures employed for Study 1 and Study 2 were quantitative. They were also devised by Western researchers and reflect Western culture. They had never been used in Bulgaria before and some questions in them do not correspond to Bulgarian culture. Analyses confirmed that the measures were reliable and valid to my studies but some aspects may not have been covered. These aspects are the multiple aspects of anxiety combined with culture specific factors different to self-construals, therefore they can only be explored with the help of qualitative methodology.

The measures used for the quantitative studies were limiting as they only considered a number of correlates (e.g. social support, self-construals). The psychological processes in the individual cannot be seen only as a summary of variables, because every individual has unique life story and psychological experience. To examine these in their richness, unstructured interviews were conducted with 10 adolescents (5 female and 5 male) and 10 adults (6 female and 4 male).

5.3. Literature review

The important aspects of anxiety that have remained unexplored in Study 1 and Study 2 but may hold key meanings for the participants include the somatic symptoms, the stress life events and death anxiety.

When people experience anxiety, they focus on the way their organism reacts to stressors. The somatic aspects of anxiety have received significant research attention over the last few decades because they can have an adverse effect on individuals. Bernstein et al. (1997) identified the most common somatic symptoms in a sample of 44 adolescent school refusers. They were diagnosed with comorbid anxiety and depressive disorders. Results suggested that the problems were concentrated in the autonomic (dizziness, heart-beat, sweating) and gastrointestinal (stomach pains) categories. These findings are supported by Ginsburg et al. (2006) who examined symptoms in children

and adolescents with anxiety disorders. The most common recorded somatic symptoms included restlessness (74%), stomach aches (70%), blushing (51%), palpitations (48%), muscle tension (45%), sweating (45%), and trembling (43%). Age differences were observed with adolescents reporting more symptoms than children, gender effects were insignificant.

McLeod et al (1986) collected self-reports and psychophysiological recordings from 20 patients with generalised anxiety disorder. They found no correlations between patients' ratings and physiological measures of somatic symptoms when patients were resting.

However, when a measure was taken during exposure to stress, directional changes were recorded - a clear indication that patients were aware of the direction of symptoms experienced during anxiety (but not their intensity).

Eley et al. (2004) investigated the association between heart-beat perception accuracy, anxiety sensitivity and childhood somatic symptoms. 79 children were assessed. No gender and age effects were observed on heart-beat perception. Participants with high somatic symptoms were seven times more likely to have good heart-beat perception and anxiety sensitivity. Similar effects were observed in adults. Van Der Does et al. (2000) examined 709 participants with anxiety disorders. Accurate heart-beat prediction was more prevalent during patients with anxiety disorders when compared to healthy controls. Heart-beat perception was also affected by physical exercise, distraction and type of treatment. They explained these findings with the schema-guided information processing. This is explained by Pennebaker (1982) who stated that people are processing sensation information all the time. Sensations are related to internal states. He argued that symptoms are interpreted based on external and internal cues and, most importantly, schema sets that people hold. As a result of this we may become of internal sensations (e.g. rapid heartbeat) even when they do not represent physiological changes

accurately. Settings and personal knowledge influence our perception of physical symptoms. (Pennebaker, 1982).

These results indicate that it is important to acknowledge somatic symptoms. Firstly, they commonly indicate underlying anxiety. Secondly, we can gain knowledge about the mental concepts that inform people about experiences and situations. Thirdly, the combination of the first two may facilitate more rapid referral for psychiatric assessment and treatment.

The experience of stressful life events, either shared with other members of the family (significant others) or unique to the individual, is related to the development of anxiety disorders. For example, many forms of childhood adversity are associated with adult psychiatric outcomes including the anxiety disorders. Holmes and Rahe (1967) identified more than 40 such events including: death of spouse, son or daughter leaving home, divorce, trouble with in-laws, martial separation, outstanding personal achievement, jail term, marriage, being unemployed, change in living conditions, begin or end school, personal injury or illness, change in residence, change in financial state, pregnancy, sex difficulties, etc.

Kessler et al. (1997) considered twenty-six adversities including loss events (e.g. parental divorce), parental psychopathologies (e.g. maternal depression), interpersonal traumas (e.g. rape) and other adversities (e.g. natural disaster). These adversities were consistently associated with onset of anxiety disorders and addictive disorders. They concluded that the effects of childhood adversities on disorder onset persist beyond childhood.

Safren et al. (2002) examined the prevalence of self-reported childhood physical or sexual abuse in a sample of adult patients receiving treatment of panic disorder, social

phobia, or generalized anxiety disorder. Patients with panic disorder had significantly higher rates of past childhood physical or sexual abuse than patients with social phobia. Patients with generalized anxiety disorder had intermediate rates of past physical or sexual abuse. In addition, anxiety disorder patients with a history of childhood abuse were also more likely to have comorbid major depression than those without.

Studies like these indicate that there are many individual risk factors associated with anxiety. Only by acknowledging their role in personal experience we can build a comprehensive account of anxiety.

Noyes et al (2002) stated that death has the power to evoke universal and cross-cultural fears of powerlessness, loss, separation, loss of control, and meaninglessness. These fears can undermine individual psychological wellbeing.

Langs (2004) identified 3 types of death anxiety: predatory (fear of being harmed), predator (fear of causing harm to others) and existential anxiety (an awareness that life has to end).

Tilich (1952) viewed existential anxiety as an awareness of one's own potential nonbeing and he listed three categories for the nonbeing and related anxiety: ontic (fate and death), moral (guilt and condemnation) and spiritual (emptiness and meaninglessness). Tilich (1952) viewed the spiritual anxiety as the predominant one in the modern world.

More recently, Weems et al. (2004) explored Paul Tillich's theory by studying adult data from two initial empirical studies (Study 1, N=225; Study 2, N=331) of Tillich's model and its relation to symptoms of anxiety. The data suggested that existential anxiety concerns are common and that they are associated with symptoms of anxiety combined with psychological distress related to identity problems. Research also suggests that

death anxiety is present in the experience of separation anxiety disorder and agoraphobia (Fleischer-Mann, 1995) and panic disorder (Fleet andBeitman, 1998).

Thorson andPowell (1988) examined death anxiety in a study of 599 adolescents and adults. Older respondents indicated a concern over the existence of an afterlife and feared loss of personal control. Women expressed more fear of pain and bodily decomposition. Rasmussen and Bremms (1995) assessed the relationship among death anxiety, age, and psychosocial maturity in 194 participants. Their findings showed that psychosocial maturity was a better predictor of death anxiety than age. Both variables were negatively correlated with death anxiety, revealing that as psychosocial maturity and age increase, death anxiety decreases.

The importance of examining experiences of death anxiety is particularly salient because it impacts all aspects of everyday life and individual functioning (Hayes, 2010).

People's own perception of their psychological state is of crucial importance for improving detection and early intervention where necessary. Kadam et al. (2001) conducted a qualitative study about views on anxiety and depression. 27 patients with anxiety and depression were recruited from a general practice and their perspectives in relation to their healthcare needs in anxiety and depression were explored. Semi-structured individual and focus group interviews were recorded and summarised. Results indicate that patients seek many different ways of coping with their problems but see their general practice as a focal point for help. Patients highlighted the inability to control negative and intrusive thoughts and to live in a threatening world. They identified a variety of barriers to help –seeking and were generally sceptical about the use of drug therapies.

In a qualitative study conducted by Dinos et al. (2004) 46 patients were recruited from community and day mental health services in London in order to explore various mental illnesses and their relationship with stigma. Its importance for diagnosis, treatment and the consequences for the individual were also explored. Results indicated that people with depression, anxiety and personality disorders were affected by patronising attitudes and feelings of stigma even if they had not experienced any overt discrimination. It affected the way people accept their diagnosis and function in the world.

Qualitative research studies like these are very rare, conducted only in Western countries and they come exclusively from patients with clinical backgrounds. There is an apparent gap in knowledge concerning general population samples and Bulgarian participants in particular and his study addresses it.

5.3.1. Interpretative Phenomenological Analysis (IPA) and its role in understanding personal experience

Quantitative methods are limited and are unable to take healthcare professionals to the core of the individual lived experience. They mainly focus on treatment outcomes, survival rates and clinical governance and do not take personal viewpoints into account.

In the last few decades, the psychosocial aspects of certain conditions have been researched successfully through qualitative methods. The method has been particularly useful in exploring health behaviours relating to patients and their psychological response to treatment, and in examining organisational behaviours such as implementing the process of change and modernising health service delivery (Murphy and Dingwall, 2001; Mays and Pope, 2000; Murphy et al., 1998).

Interpretative Phenomenological Analysis (IPA) is a relatively recent psychological qualitative approach. It is now being used widely by researchers in clinical, social and

health psychology in the UK and other countries. It has also been adopted by other researchers in the health, human and social sciences.

IPA's aim is to understand lived experience and especially how participants themselves make sense of their experiences. Therefore it is focused on meanings which those experiences hold for the participants. The experience of anxiety is subjective, therefore the participants' personal accounts provide valuable information for the psychological impact of the condition.

IPA is phenomenological, its purpose is to explore an individual's personal perception or account of an event or condition as opposed to attempting to produce an objective record of the event or condition itself. IPA originated with Husserl's attempts to construct a philosophical science of consciousness. It gives the researcher the opportunity to develop an idiographic understanding of participants, and what it means to them, within their social reality to live with a particular condition or be in a particular situation (Bryman, 1988). An IPA study explores the meanings particular experiences, events and states hold for participants. It involves detailed examination of the participant's life world and explores personal experience and perception.

IPA is consistent with its phenomenological origins, therefore is concerned with trying to understand what it is like from the point of view of the participants. At the same time, a detailed IPA analysis includes asking critical questions of the transcribed texts, for instance: What is the respondent trying to achieve here? Did they say something that wasn't intended? Is there something going on here that maybe the participants themselves are less aware of?

IPA is defined by phenomenological understandings of lived experience as context-dependent and determined by social, historical and cultural perspectives. Eatough et al.

(2008) explored the emotional dimensions of anger and aggressive behaviour in women. Through IPA they were able to capture the richness and complexity of the lived experience of emotional life. In particular, they drew attention to the context-dependent and relational dimension of angry feelings and aggressive behaviour. Researchers assessed the subjective experience of anger which included bodily changes associated with certain emotions, different forms and contexts of aggression and individual perceptions of unfairness occurring with anger.

Smith et al. (2009) provided a detailed overview of IPA and discussed its practical implications. Four distinct topics within psychology were included in their book with individual examples from their work: health and illness, sex and sexuality, psychological distress and life transitions and identity. This wide variety of topics indicates a dynamic and comprehensive nature of IPA. The method was also employed by Roose and John (2003) to study children's views of mental health and concurrent service provision for mental health problems. It was conducted via focus groups in order to address appropriate service development for the needs of children and young people.

Studies like these highlight the suitability of IPA for social and psychological interpretations of data. It is a flexible method which allows working with large amount of qualitative data and follows the individuals' perceptions and experiences. These aspects make it an appropriate method for the purposes of this qualitative study.

5.4. Method

5.4.1. Participants and Procedure

One of the best ways to collect data for an IPA study and the way most IPA studies have been conducted is through the unstructured interview (Smith et al. 2009) and thus this was considered when the method was adopted for the purposes of anxiety exploration.

This form of interviewing allowed me to ask one single core interview question and in the light of the participants' responses I was able to probe interesting and important areas which arise.

Respondents were selected randomly from a sub-sample of Study 1. 10 adolescents and 10 adults were chosen from a sub-sample of 147 adolescents and 62 adults who took part in Study 1 and gave their permission to be re-contacted for the qualitative part. All 20 interviews (10 in the adolescent group and 10 in the adult group) proceeded without interruption as far as possible, and the interviews were conducted with the respondent alone. As people usually feel most comfortable in a setting they are familiar with, the interviews took place in a private room located in their immediate everyday surroundings (school and work respectively). At the beginning of the interview, the focus was on putting respondents at ease, to enable them to feel comfortable talking to the researcher before the core question was asked:

Please, tell me how does anxiety make you feel?

The open –ended nature of the question allowed for a variety of individual responses, shaped entirely by personal dispositions, verbal tools and unique interpretations: from physical discomfort (bad rash, sweating, passing out) through feelings of guilt, duty, cultural boundaries and even fears of paranormal proportions and superstitions.

Respondents were prompted for clarification for specific events, fears and feelings with the questions: “What kind of situations and people might make you feel anxious? And “Can you give me more information about this?” All interviews were fully recorded and transcribed – Langdridge (2007) and Smith et al. (2009) considered the recording part crucial for capturing the unique atmosphere – pauses, verbal expressions, intonation and stress on particular words.

Data collection for IPA does not test hypotheses so data was approached without assumptions. Every analyst has own preconceptions about the data and attempts to reflect on these and focus on grasping the experiential world of the research participants. Transcripts were coded in considerable detail and throughout the analysis there was shifting back and forth from the claims of the participant, to our interpretation of the meaning of those claims.

Several strategies were considered during the analytic process:

- The close, line-by-line analysis of the participants’ claims, concerns and understandings
- The identification of the emergent themes within this experiential material usually first for single cases and then subsequently across other cases.
- The development of a correspondence between my views, the data coded and my psychological knowledge about what it might mean for participants to have these concerns in this context and their interpretation
- The development of a structure reflecting the relationship between themes.
- Organising analytic material: comments, clusters, developing themes
- Testing the interpretation’ plausibility

- A detailed commentary on data extracts theme by theme and is often supported by a visual illustration (table)

- Reflection on investigator's own perceptions and conceptions

5.4.2. Analytic steps (Smith et al., 2009)

5.4.2.1. Step1

The first step of an IPA analysis involved immersing oneself in the original interview data. The audio-recording was listened the transcript was read a few times. This first stage was conducted to ensure that the participant becomes the focus of the analysis. For every participant, the most interesting observations were recollected. Repeated reading of raw interviewing data allows to follow the rhythm of an interview and gradually goes from general in the beginning to specific towards the end of the interview.

5.4.2.2. Step 2

The so called initial noting where language was marked on an exploratory level. The main purpose of this stage was to establish familiarity with the transcript. Descriptive comments were written regarding processes, emotions, events, relationship with others, etc., whilst ensuring that the meaning of those things for the participant and the context were taken into account. This is where more abstract concepts started to emerge from concrete data, allowing for consequent understanding of patterns of meaning in the transcripts. This process is illustrated in the box below which contains an extract from an interview with Anna (a pseudonym), a 14-year old Bulgarian female who talks about her own experience of anxiety. The interview is used to illustrate the multiple ways in which explanatory commenting can be conducted. These are broken down into three separate processes with different focuses:

1. Descriptive comments –these are related to the content of what the respondent has said (normal text)

2. Linguistic comments –participants' use of language (*italic)*

3. Conceptual comments – these involve comments regarding concepts in interview data (<u>underlined)</u>

These comments formulated an analytic conversation with the transcript and although they were not exhaustive, they establish an effective engagement with the data. The main purpose of this task was to ask questions about what each word or sentence means for me and what it might mean for the respondent. A table of initial comments can be found in Appendix XVII.

Descriptive comments:

Key words, phrases or explanations which the respondent used were recorded to aid understanding of things which matter to him/her. This level is about highlighting the objects which structure the participant's thoughts and experiences. As the analysis develops, richer accounts of the meanings of objects were constructed. Anna's fear became more and more prominent as we have moved on from her appearance and peer relationships to her family traditions, fear of dying and moral values.

Linguistic comments:

The most important issue here is how the transcript reflects the way in which the content and meaning were presented. Pronoun use, pauses, laughter, repetition and contrast, tone and use of figures of speech are some of the things to record. Metaphors are particularly powerful components of the analysis. Anna's use of

metaphors was limited but other participants' speech was much more colourful when it came to the use of rhetorical tropes and figures.

Conceptual comments:

Conceptual comments involve discussion, reflection and definition of ideas. An example of this sort of comments is moving away from focusing on the particular meanings of specific difficulties with relationships (peers, family) which have stemmed from Anna's inner insecurities and pre-occupation with appearance and behaviour, and moving towards an account of future plans, responsibilities and morals.

The so-called de-contextualisation was also used to get a good feel of Anna's words. This involved fracturing of the transcript and moving sentences around as well as reading whole paragraphs backwards to emphasise on particular phrases. For instance:

They give me bad dreams and I can't sleep properly. My great grandfather died two years ago and I cried a lot – I hate funerals and cemeteries. I was scared that he would kill us - I am terrified of dying. Me and my older sister were alone, so we ran to our neighbours for help. I am also scared of drunk people – no-one in my family drinks alcohol, but once we had a drunk person trying to break into our house. I am scared that people would notice so I wear a long fringe. I do not want to go to the opticians as I do not want to wear glasses and my mum is having a hard time trying to convince me to go, as I have problems with my eyesight. I feel it there when my dad is driving very fast on the motorway, it makes me feel dizzy. Anxiety is like a dry patch in my mouth.

This task enabled me to avoid simplistic reading and helped to see the interrelationships between experiences together with causality and emotional consequences.

Overview of initial notes

The example from Anna's transcript provides a sense of both the complexity and open-ended nature of exploratory commenting. There are many other ways for doing initial noting, so the approach is not meant to be exhaustive. The process of engaging with the data is almost as important as the actual physical task of writing on the transcript itself. Free associating form the participant's text and writing down whatever comes to the mind when reading certain sentences and words also help to expand exploratory noting.

Example (the associations are in italic):

I am afraid that I will disappoint my parents (*matriarch, stern, authoritative, support, promises, upbringing, wishes, expectations, they **** you up by Philip Larkin)*. My parents want me to be a lawyer (*long hand of law, justice, obedience, crime, punishment, prison, witness, victim)* as four generations of my family have worked as lawyers. But I just do not find law interesting (*exciting, stimulating, corresponding to/opposed to individual nature, fulfilling, risky, intriguing*). So I am scared to talk to them about my choice of career (*free will, knowledge, biblical motives*) as a good daughter will not disobey the family traditions (*lack of changes, old, stuck in the past, values, regress, comfort, no development).* Sometimes I feel like speaking, but the words just do not come out – my heart starts beating faster, my eyes become sore and I just say to myself "maybe another time" (*pain, discomfort, boundaries, Echo and Narcissus*). I do not want to see my mum crying - as she and my dad are very good *("good" is always tied to something else – good parents, good daughter, but not GOOD as a major category or positive entity, philosophical /ethical)* parents to me and my sister. Even at hard times we had everything we could wish for – pets, nice clothes, lovely holidays (*childhood, friends, games, freedom, laughter, innocence*). I dread the moment when she (the mother) will say to me: "You have failed us, we gave you

everything and what you have done is unacceptable" (*duty, escape, conformism, mistreatment, verbal abuse, vulnerability*). You see, one of us, me or my sister will have to keep the tradition alive, but she did not perform well in school because of her learning difficulties, so it is entirely up to me (*pride, self-sacrifice, idealism, beliefs*). And I do not want to feel guilty (*dirty, bad, secret, forbidden, selfish*) But I cannot be a bad daughter either. Once my mum caught me smoking a cigarette (*poison, self-harm, attention seeking, wanting to be popular/grown up*) and I will never forget the look on her face – I promised (*devotion, keeping true to one's word, putting own wishes aside, mum's wish is sacred, worshipping*) her I would never do it again and I haven't. A cigarette is just a one-off, but a choice of career is for life (*premature wisdom, little adult, too serious),* so I can not disappoint them.

This approach is also a part of the fluid process of engaging with the text in detail, exploring different meanings which arise and preparing the analyses for a more interpretative level.

5.4.2.3. Step 3

The third step included the developing of emergent themes. Although the interview was central in terms of data after our exploratory commenting, the data set grew and emergent themes started to develop. Here there was a shift to working with notes, not only with the transcript, but the two remained closely connected.

The transcript became a combination of parts that come together in another new whole at the end of the analysis during the write-up. Now there is more of me in this part in the analysis, the end product is a collaboration between my efforts and those of the participants. All the parts were interpreted in relation to the whole and the whole was interpreted in relation to the part. A table for emergent themes from Anna's transcript can be found in Appendix XVIII.

Themes reflect not only Anna's words and thoughts but also my interpretation and whilst initial notes are open and a bit chaotic, themes show understanding of Anna's viewpoint. For instance, the first emergent theme, the powerless self captures the initial exploratory notes relating to language use and Anna's inability to cope with anxiety related emotions. It is a struggle still perhaps apparent within the interview as Anna attempts to articulate what is going on at this particular time in her life. The theme title relates directly to the content of Anna' s talk and her struggle to deal with the overwhelming nature of anxiety. Within the theme title, the use of "self" reflects interest in the psychological construct of self. The theme brings together a range of understandings relating directly to both of us.

5.4.2.4. Step 4

During this stage connections were established across emergent themes. These were mapped and decisions were made about how they fit together. Only themes which were considered important, interesting and relevant to the scope of the research were kept, so the selection was not by any means complete and could be reconsidered at any time during the remaining stages of the analytic process. Here is how this was done:

> After identifying patterns between emergent themes and developing a sense of the so called "super-ordinate theme", a new name for the cluster was devised. If we think about Anna's extract, there are a series of emergent themes around the family/social impact on her anxiety, such as: 'excessive thinking (rumination)', 'lack of self-esteem', 'copings as a process', 'loss of future/expected self', 'the interdependent self' and 'family relationships as problematic'. These can be grouped together under the super-ordinate theme "The psychological impact of social/family relationships on anxiety". The super-ordinate theme emerges at a higher level as a result of putting the themes together.

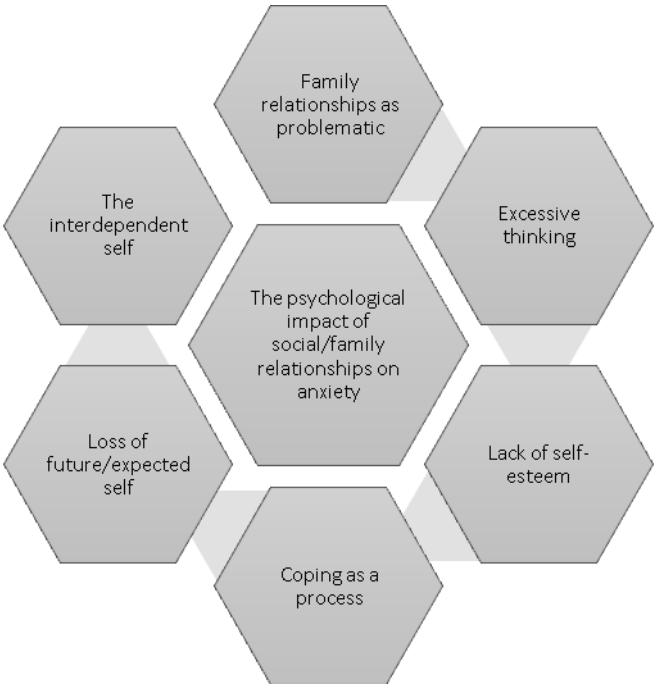


Figure 5.1 Development of a super-ordinate theme for Anna (14)

Within the interview with Anna there are many critical 'events': The moment when someone broke into their property, the death in the family, the occasion when she was caught with a cigarette. These themes could be organised in terms of the temporal moment where they were located. By looking at the way they were connected, I was able to make sense of many contextual details.

The frequency of occurrence of themes was also noted, but not over-emphasised. It did indicate importance, but after all, a very important theme, which clearly led to a further set of meanings for Anna was the 'mortal self' and it was mentioned only once.

Themes were also evaluated by their positive and negative presentation in order to find out what participant presents in terms of their meaning. The participant presents herself throughout the interview. So negative aspects of the way Anna sees herself such as 'lack of self-esteem' and 'self- criticism' could be seen as serving to position Anna as a 'victim' of circumstance (eliciting care and sympathy from the listener) while positive

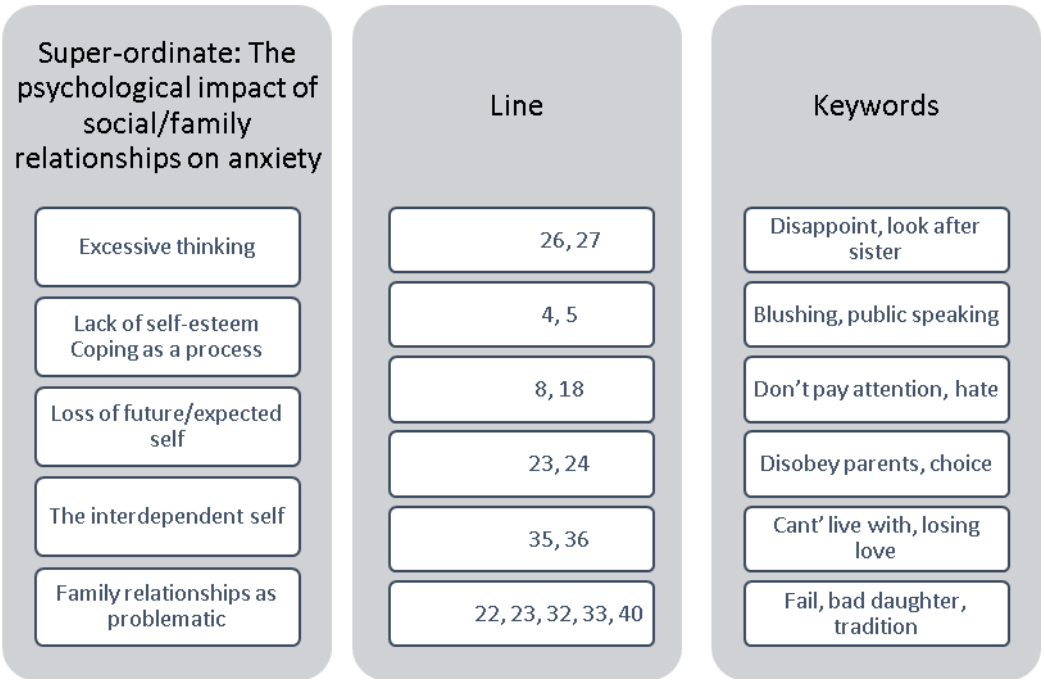
themes relating to 'exploring the self as a process' such as 'the academic self-perspective' and 'self-sacrifice' could be seen as means of positioning herself as a 'survivor' or 'hero' within the narrative (eliciting praise and positive affect form the listener)

After organising themes in the above mentioned ways, a graphic representation of the analysis was prepared with references to lines from the transcript and particular keywords. This is reflected in Tables 5.1. and 5.2.

Table 5.1. Exploring the self as a process for Anna (14)

Super-ordinate Exploring the se as a process	Line	Keywords
The powerless self	3, 7	Nothing can help
The self as an image	12, 13	Glasses, fringe, hiding
The self as a performance	8, 9	Good schoolwork
Work on managing the self Themes:	5, 8, 24, 25	Procrastination

Table 5.2. The psychological impact of social/family relationships on anxiety for Anna (14)



5.4.2.5. Step 5

The process was repeated for the next participant's transcript. The steps were followed systematically to ensure that emergence of new themes was recorded. Appendix XIX contains an extract from an interview with Stephen (a pseudonym), a 17-year old Bulgarian where all the emergent themes, the original transcript and the initial descriptive (normal text), linguistic (*italic)* and conceptual (underscored) comments are recorded. Tables 5.3. and 5.4. show the super-ordinate themes and themes for Stephen (17).

Table 5.3. Wanted/Unwanted self for Stephen (17)

Table 5.4. The psychological impact of family relationships on anxiety

Super-ordinate: Wanted/Unwantec self	Line	Keywords
Undesirable feelings	9, 10	Not afraid anymore
Work on managing the self	10, 11	Results, good life
Unwanted self is rejected	13, 14	Not a life I want for me
The independent self	18, 19	Leaving the country
The interdependent self	34, 35	Looking after, guilty
Self-ownership	36	Sacrifice my dreams
Self-control	21, 22	Control, emotions, shout
Pro-social behaviour	22, 23, 32, 33	Calm, good manner, bad influence

Table 5.4. The psychological impact of family relationships on anxiety

Super-ordinate:The psychological impact of family relationships on anxiety	Line	Keywords
Family relationships as problematic	27, 28	Nerves, older one
Dynamics of relationships in the family	29, 30	Safe, protected, duty
Intensity of engagement in controlling behaviour	33, 34, 35	Best for her, personally responsible

5.5. Results

Super-ordinate themes were configured overall when all transcripts were analysed. These were ‘The Adolescent Self’, ‘The family relationships as a cause for anxiety’,

'Adolescents and their place in the social world' and 'The future'. There was a wide variety of themes within every super-ordinate theme. In order to allow an efficient comparison between qualitative results for both groups, the super-ordinate themes for Adults were labelled in a similar way but included different themes within – each one was specific to the age group that was represented. The most important difference between the superordinate themes for both age groups is that "The Future" in the adult group could not be viewed and understood without the presence of "The past" which was omnipresent in the adult interviews when they shared their experiences of anxiety.

5.5.1. Adolescent super-ordinate themes and themes

Figure 5.2. presents the super-ordinate themes for the adolescent participants.

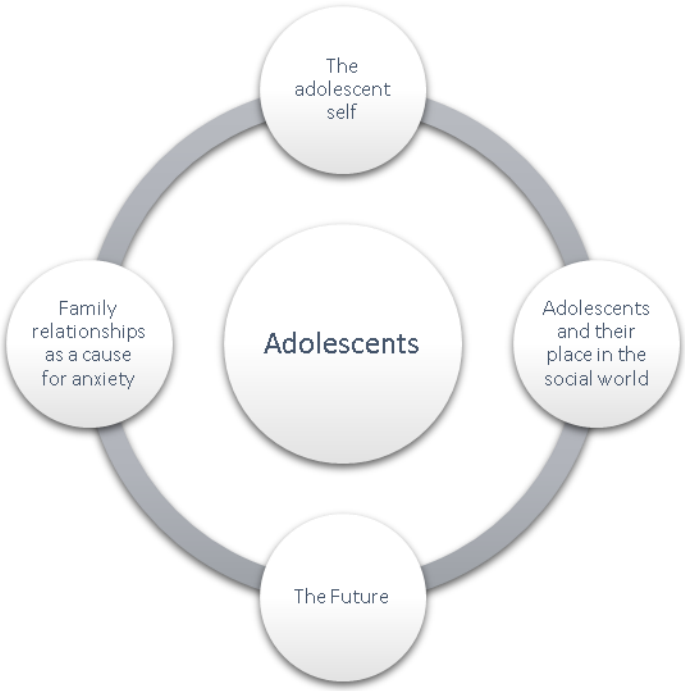


Figure 5.2. Super-ordinate themes for adolescents

The emergent themes which were grouped under each super-ordinate theme are presented in Figures 5.3. and 5.4.

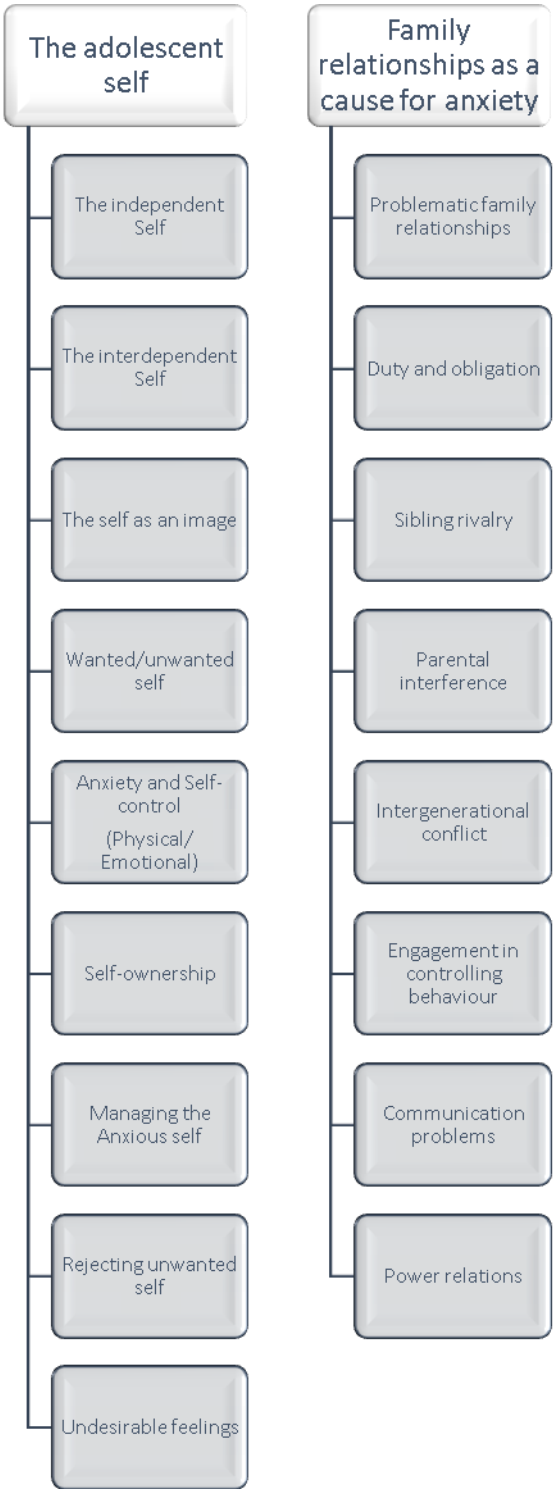


Figure 5.3. The adolescent self and family relationships as a cause for anxiety

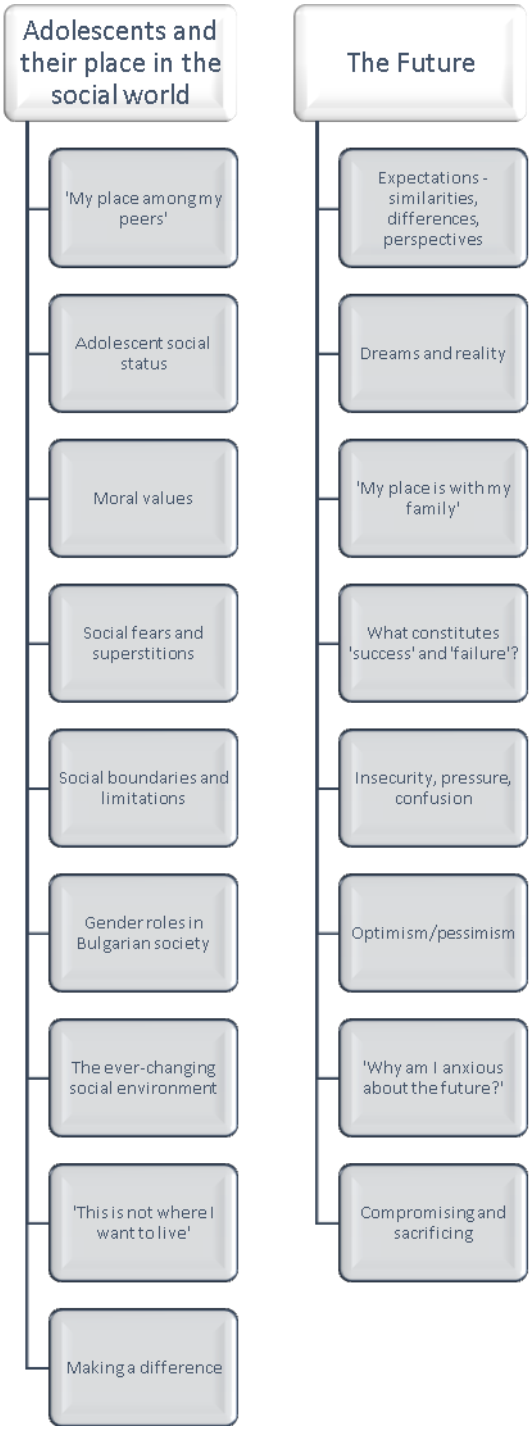


Figure 5.4. Adolescents and their place in the social world and The Future

5.5.2. Adult super-ordinate themes and themes

Figure 5.5. below presents the super-ordinate themes for the adult participants.

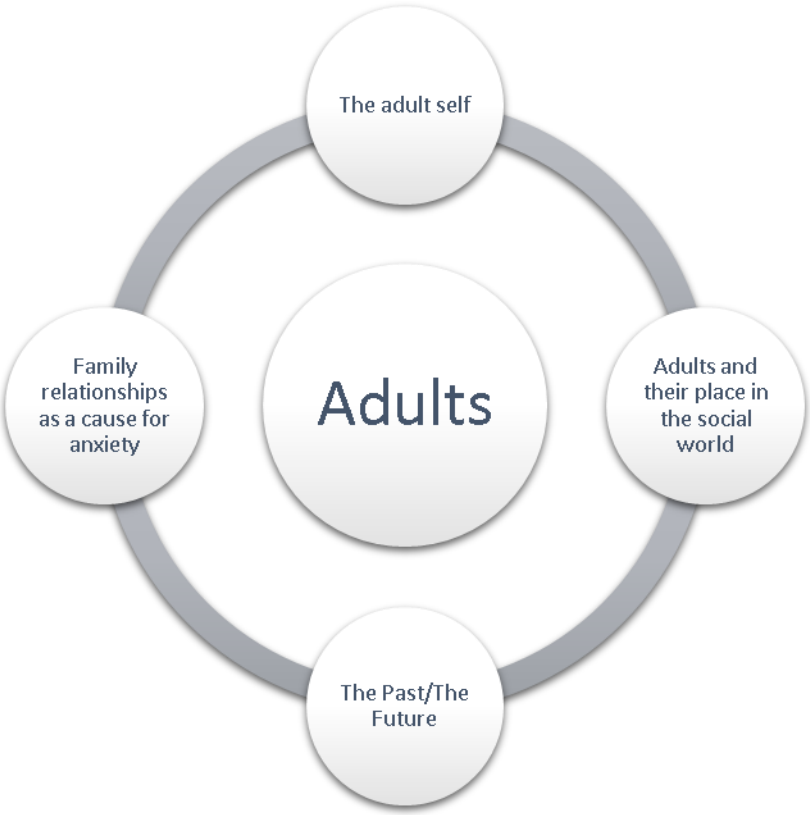


Figure 5.5. Super-ordinate themes for adults

The emergent themes which were grouped under each super-ordinate theme are presented in Figures 5.6. and 5.7.

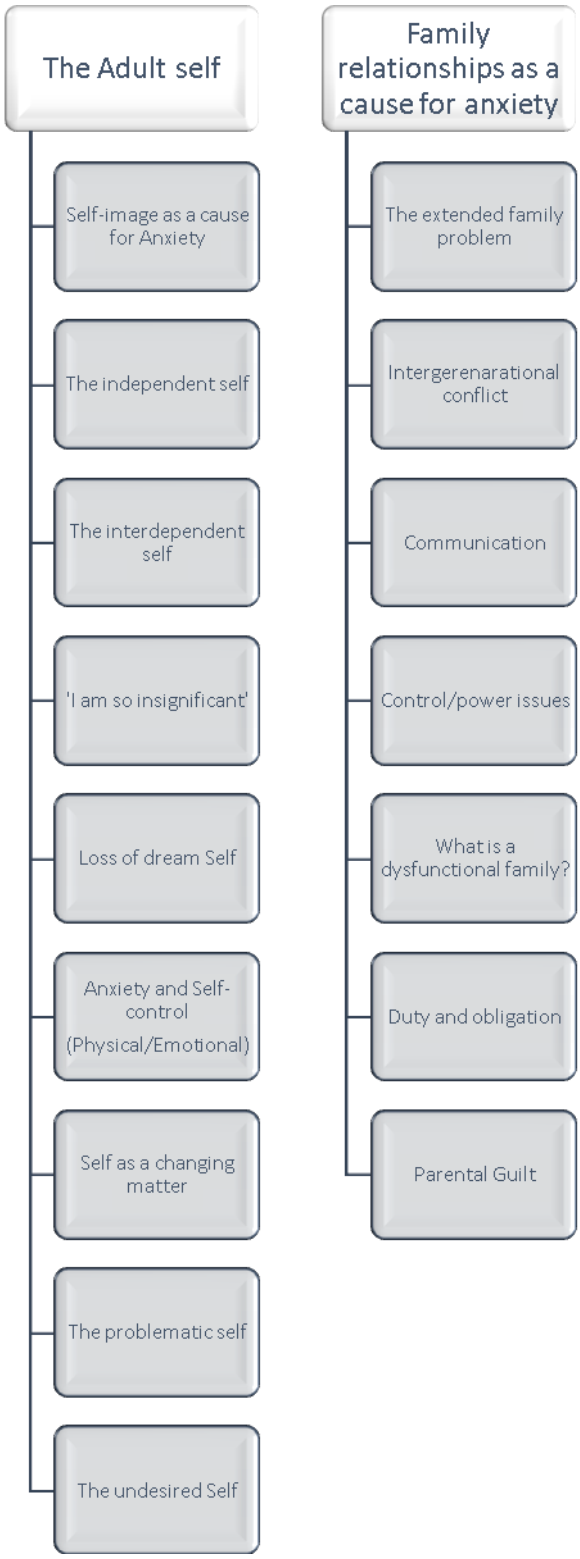


Figure 5.6. The adult self and Family relationships as a cause for anxiety

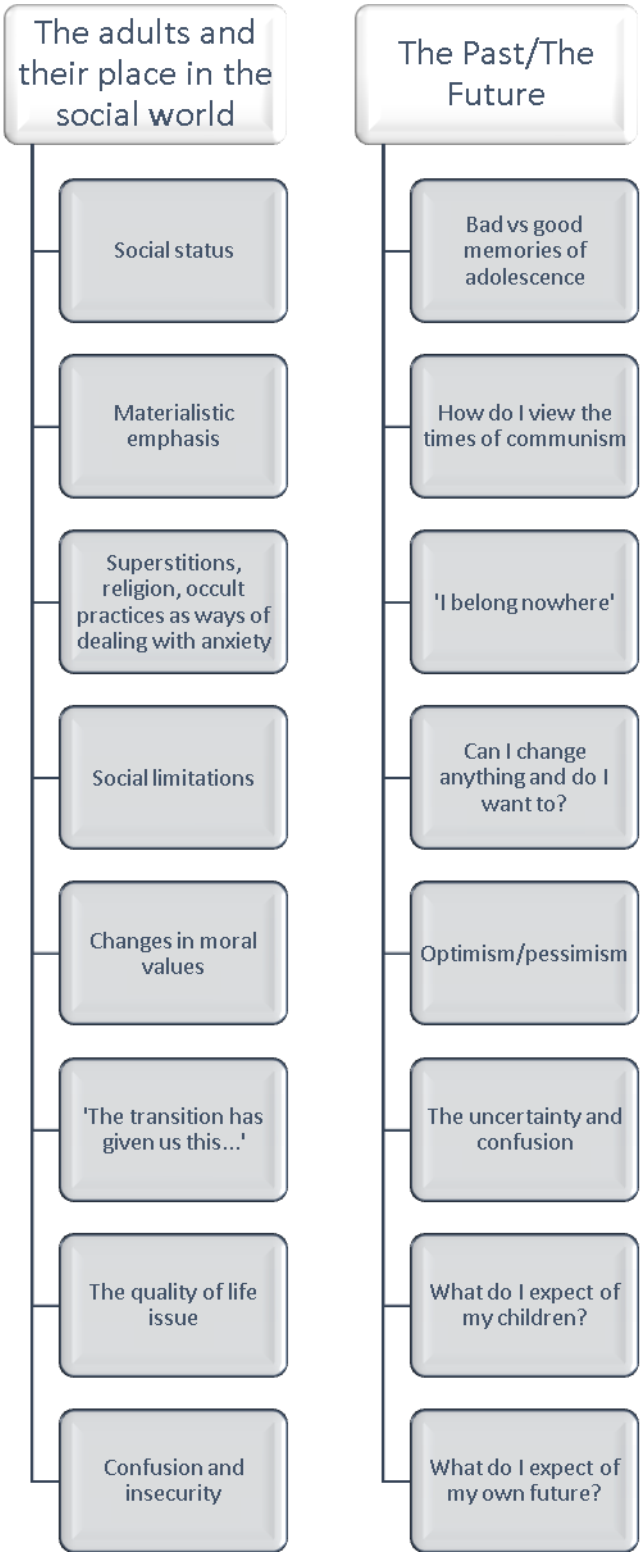

The adults and their place in the social world
Social status
Materialistic emphasis
Superstitions, religion, occult practices as ways of dealing with anxiety
Social limitations
Changes in moral values
'The transition has given us this...'
The quality of life issue
Confusion and insecurity
The Past/The Future
Bad vs good memories of adolescence
How do I view the times of communism
'I belong nowhere'
Can I change anything and do I want to?
Optimism/pessimism
The uncertainty and confusion
What do I expect of my children?
What do I expect of my own future?

Figure 5.7. The adults and their place in the social world and The Past/The Future

5.6. Discussion

- The Self and anxiety from a qualitative point of view

The multidimensional aspects of the developing and changing Adolescent Self proved to be a major source of anxiety for the participants in this study. Physical appearance was almost universally acknowledged by adolescents as a substantial part of their identities but was also defined by uncertainty and negativity. For Anna (14) there was a constant self-awareness of her speech defect and somatic responses to anxiety. She was distancing herself from social situations to avoid being ridiculed. The situations outlined in this paragraph meet some of the criteria for general and social phobia, but it is vital to acknowledge the gelotophobia ('fear of being laughed at') which she unsuccessfully tries to denigrate by stating "(they) can't help laughing at me"). Edwards et al. (2010) view the gelotophobia as a syndrome that is related to, but distinct from, social phobia. It develops in part from "repeated experiences of being the target of teasing and ridicule relating particularly to anxiety-based social skills deficits and interpersonal awkwardness."

> *...My palms get sweaty, I feel hot and start blushing. I feel anxious before exams or when I have to speak in front of the whole class. I do not like attention very much and prefer to sit quietly. Sometimes I have difficulties speaking because of my lisp and when I am anxious I speak even worse. Some of my schoolmates are understanding, but others can't help laughing at me from time to time.*

In addition, she developed a way of creating a physical and emotional barrier between her and the rest of the world. The fringe is rather symbolic in its functional nature as observed in this paragraph. It is evident how Anna (14) intensifies usually minor

worries about the body and shows preoccupation with them. To other people these might seem non-existent or minimal defect in appearance, but for her they generate significant distress and impairment in social, relational and other important areas of life. Note that it also involves unrealistic beliefs in other people's reactions to this 'ugliness'. Philips et al. (1995) considers such behaviour as indicative of Body Dysmorphic Disorder and notes that 'preoccupations have been noted to structurally resemble obsessions in that they are distressing and anxiety producing, persistent recurrent thoughts that are difficult to resist or control.'

> *… . I do not want to go to the opticians as I do not want to wear glasses and my mum is having a hard time trying to convince me to go, as I have problems with my eyesight. I am scared that people would notice so I wear a long fringe…*

For Donna (15) the negative self-image as a part of her developing identity is revealed in this profound description of her battle with weight which has led to excessive anxiety and pre-occupation with potentially dangerous practices.

> *… People who tease me about my weight are very cruel. I have always been a bit chubby, but since reaching puberty, things have become even worse. I have been on every diet possible in my short life – because I have tried Atkins, I now have problems with my kidneys and I have developed some food intolerances, because I have deprived my body of some nutrients and gave it toxic quantities of other stuff. I know I have been stupid to put my health in risk, but I felt desperate. I regret it now because it hasn't worked – if anything, my temporary weight loss has resulted in me putting even more weight afterwards...*

Donna (15) shows that she is aware of the health consequences and at the same time she recognises that these are not her primary concerns. The maintenance of this negative

body image through the weight gain is the severe emotional issue here which leads to anxiety. The strong use of words (‘deprived’, ‘toxic’) and the willingness to disclose every single detail about her ongoing battle with weight indicate an emotion-oriented coping with the problem. According to Koff and Sangani (1998) this is a risk fact as it could be associated with other measures of psychological distress and psychopathology. Identifying it early would help to break the pattern that feeds the negative body image. Michael (15), gave the following summary of his body dissatisfaction and placed it in a social context:

> *…I am a bit overweight and I do not think that I am handsome, so all these things are a bit strange to me. I worry sometimes that I will never be popular if I look like this, but some people go to great lengths to become the centre of attention and I want to avoid that. There are guys in our school, who are like 16-17 and they take performance enhancing drugs and anabolic steroids to pump up their muscles. It is a very dangerous practice that is unfortunately becoming commonplace now. People put their health at risk to become ridiculously inflated and girls dream of having plastic surgery and being a size 0. There is so much pressure on us to look in a certain way from a very early age and teenagers who do not look this way feel like a failure and get depressed…*

What we have in this paragraph is a very interesting and mature perspective which seems to be in accordance with previous research findings about the differences between body images of adolescent boys and girls. Michael is distancing himself from extreme body alterations, and places himself above vanity issues by using contrasting language. ‘A bit overweight’, ‘a bit strange, ‘worry sometimes’ are indicative of his wish to portray physical image as a small and non-significant part of his life. At the same time, he is quite competent about other people’s dangerous behaviour by

disclosing a lot of information about banned substances used by others. Carlson Jones (2004) conducted a longitudinal study of adolescent girls and boys and examined the contributions of social (peer appearance context), psychological (internalized appearance ideals and appearance social comparison), and biological (body mass) factors to the development of body dissatisfaction. Students completed questionnaires when they were either in 7th grade or 10th grade and again 1 year later. The results for the boys revealed a singular pathway to body dissatisfaction through internalized commitment to muscularity ideals. The analyses of change in body dissatisfaction among the girls reflected the contributions of appearance conversations with friends, social comparisons with others' appearances, and body mass.

Kristina (13) did not express any anxiety concerns related directly to body defects but added another dimension to the negative body image by emphasising on the importance of outer appearance and its role for establishing oneself among peers.

> *…Of course, I worry about other things – such as school performance and the fact that I am unable to dress as well as I want to. There are some very well dressed girls at our school, who always wear lovely accessories and shoes and it affects me badly because I can not afford these. This is why the boys never notice me and other girls do not respect me, I am just invisible. I know it is more important to be a good person and to be kind to others, but sometimes this is not enough to feel confident and worthy of attention. I am the only one in our class who can not afford a laptop at the moment and I feel left out…*

Kristina (13) places so much emphasis on the relationship between class, money and image that everything else seems insignificant and easy to overcome. She thinks money is the reason for all of her confidentiality issues and worries, a view which was far from unique among our adolescent (and adult) participants. Stephen (17) seems to share this

view, going even a step further by placing these fears in the future and viewing money as one of the defining factors for life success. A 'small salary' is the main characteristic of a future unwanted Self, rejected and feared by this participant.

> *…In fact, I am quite scared that I might fail and end up having a boring life and a small salary…*

The materialistic emphasis is evident also in this paragraph from an interview with Justin (16) where he attempts to detach himself from such shallow aspirations by viewing them as typical of people who are not valued by him. At the same time he is also worried about 'lack of money'.

> *…Other things that make me feel anxious are the lack of money and glorifying of stupidity and vanity in the media. Everyone is famous for doing nothing and young people such as myself start associating lavish lifestyles with being useless and uneducated. I try not to be like that, but the other guys in the team are like this – they fancy bimbos and they dream of luxury cars and little else…*

The frequent presence of financial anxiety and the money worshipping among Bulgarian adolescents could be a result of the difficult economic situation in the country. Wadsworth and Compas (2002) identified a variety of age appropriate stressors related to a lack of money for purchasing basic goods and extras which seem important for the adolescents. They concluded that these types of problems were gruelling and demoralizing for adolescents by undermining their sense of control. This low sense of control with regard to economic pressure is associated in literature with depression and anxiety (Conger et al., 1999).

- Family relationships a source of anxiety

Another major source for anxiety in adolescents are family relationships. They are closely related to the issues of independency and interdependency and cultural values and morals. For Anna (14) the main problematic issue is her sense of duty and obligation. It prevents her from making certain choices and living her life independently. This is evident in the following extracts from the transcript.

> *…I am afraid that I will disappoint my parents. My parents want me to be a lawyer as four generations of my family have worked as lawyers. But I just do not find law interesting. So I am scared to talk to them about my choice of career as a good daughter will not disobey the family traditions…*
>
> *... You see, one of us, me or my sister will have to keep the tradition alive, but she did not perform well in school because of her learning difficulties, so it is entirely up to me...*
>
> *... My biggest fear is losing their approval and love – this is something I will not be able to live with. One day when my parents are gone, I will probably have to support my sister and I need to be well-off financially...*

These fears are essentially collectivist in their nature. According to Triandis (1995) the goals and interests of the group are emphasised over those of individual members in a collectivist society. The decisions and behaviour of young people in these societies are expected to reflect the needs values and expectations of the larger group (Markus and Kitayama, 1991) The family as the main domain of these values is where collectivist culture is expressed. This is also well illustrated in this paragraph from the interview with Stephen (17).

> *...Me and my sister who is only a year younger occasionally get on each other's nerves. Ever since we were little my parents have taught me to be kind to her and*

> *to let her have things her own way, because I am the older one and I am a boy. I should make her feel safe and protected – and no matter how annoying she can be, I still do it, as it is my duty. And I fear something bad will happen to her if I don't. Her first love was an absolute waste of space – he was mixing with the wrong crowd and creating a lot of trouble. I did not want this kind of influence on her, my parents were not keen on him either. Luckily it is all resolved now and they have separated, but if something bad happens to her, I would feel personally responsible. I want the best for her. If I leave the town or the country I will not be able to look after her properly and that makes me feel guilty…*

This extract is particularly interesting in a number of ways. It creates a full picture of a family situation that follows a strictly collectivist code: the younger sister who is being looked after by the protective older brother who engages in controlling behaviour and the parents who consider their duty to protect her at all costs. Naturally, these create a prerequisite for considerable distress and anxiety among young people in this family – Stephen and his sister give priority to the wishes of their parents and downplay their own (she has separated from someone whom her family did not approve of and he is prepared to sacrifice his dreams of overseas education and a career to fulfil a family obligation). According to Chao (1995) collectivist family dynamics emphasise on the role and authority of family and respect is paramount among younger members of the family. They are expected to make personal sacrifices and sublimate their needs and wishes for the greater good of the larger family. These is a hierarchy in place and often young people are expected to put the needs of other older adults: grandparents, uncles, cousins, etc. before their own wishes. This paragraph from the interview with Justin (16) seems to reflect these specific family arrangements.

> *…She (the grandmother) lives with us and she is the one, who always makes sure that I have breakfast, ironed clothes and I have revised properly my school stuff. Seriously, nothing has changed for her since I was five and she started teaching me how to write letters. I love her to bits, but all this care is a bit too much sometimes...*

In the interview with Peter (14) the fear of facing eventual family problems in the future becomes a much more complicated issue, as it unlocks many uncertainties and lifts the veil about specific social problems such as the societal views about particular ethnic minorities. To this participant they caused a great level of anxiety and made him lose his sleep over worry.

> *...I am also scared of losing one of my parents, because they argue a lot sometimes for all sorts of things –money, work or the time they need to spend with me. Our grandparents also interfere and things become even worse. I do not want them to divorce as I love them both, but it becomes unbearable sometimes. I fear that if they divorce, my mum will have to leave our flat – because it was bought with my paternal grandfather's money and we will need to move into a council property. I am afraid I will have to change school and I will lose my friends. The council properties are very close to an ethnic minority (Roma gypsy) area and there is a lot of crime, drugs and poverty in the area. I really hope it is not going to happen, as it would make very unhappy.*

The lack of control and the loss of a desired future Self, caused Peter a greater distress than the pending divorce of his parents. The patriarchal role of the grandparent in his extended family highlighted another aspect of anxiety, associated with complicated living arrangements of many Bulgarian families. We can see how in the following

extract from an interview with Hugo (52) there is as immense suffering as a result of him losing contact with his extended family combined with financial anxiety.

> *…My pension will be about 110 euros per month after I am 65, if I live that long. You understand that it is impossible to survive with this amount of money. My son does not want to speak to me – we have not spoken since me and his mother got divorced 8 years ago. I am not optimistic now that one day he will change his mind and acknowledge my existence again, so I am on my own and have no other people to rely on. I am anxious that noone cares what will happen to me and it drains my energy…*

In this extract from Elinor's (38) interview we can see how duty and obligation are described from her viewpoint.

> *…My parents were helping me a lot before, but since my father died, my mum got very depressed and she was put on strong medication. She is not the person she used to be, she is very often inadequate and I cannot rely on her anymore. I am anxious every time when the phone rings, because it could be some bad news. Once I had my parents' neighbours on the phone – they called me to tell me that my mum has disappeared overnight and the police were searching for her. She was found in a town about 12 miles from our own and she could not recollect how she got there, when or why. Things like this make me extremely nervous. She would not go into a nursing home – there is still this thing in older people's minds that if they end up in a care home, their life has failed. Older people entirely expect their children to look after them and if they do not do this, they are ready to disown them…*

Elinor's fears for her mother's well-being combined with the inability to change her parent's expectations or her own feelings of guilt and helplessness, create a very complicated picture of anxiety. Apparently among Bulgarian adults the so-called familism (obligation) to family members and interdependency as defined by Pan et al. (2013) were still prevalent despite the 25 years of democracy promoting individualism and independency. Moreover, it was still prevalent among their adolescent offspring as seen in our sample. Adolescents, who have never experienced communism, were still living by its collectivist arrangements and expectations as a result of their upbringing.

However, the fear of losing the wholeness of the family was not present among all adolescent participants in our sample. Diana (17) adopted a fiercely independent and individualistic stance in her interview, perhaps precisely because she wanted to break the tradition and because she has accumulated a lot of anger towards the collectivist model.

> *…My mum drives me crazy, so does my brother. And in fact everyone who tries to tell me how to live my life, what to do, what to like, how to behave. They just do not respect my right to make choices, to do what I want and to be who I am. I am anxious that they would never accept the fact that I will be an adult very soon and they cannot interfere with my decisions. They have done so in the past and I regret it very much, but very soon they will not be able to do so. I cannot wait to turn 18 and to move out. They made me split up with someone I loved very much and abort his baby. I would never forgive them and myself for letting this happen. They say that one day I will thank them for this, but I seriously doubt it. I hate it when they think they know better than me and I fear they will never learn…*

We see her as fully determined to leave the family which she associates with negative emotions, doubts and traumatic history. She felt betrayed, disrespected and failed by her

family members and was looking forward to the ability to take her life in her own hands when she becomes an adult. There was strong evidence of parental marital unhappiness in her interview, a factor considered by Balswick and Macrides (1975) as the strongest correlate in self-defined adolescent rebellion. Her desire to prove herself capable of making her own decisions could be partially contributed to the restrictive permissiveness of the child rearing practices in her part of the country (and her family specifically) and the division of authority. Balswick andMacrides (1975) saw these as sources for anger, frustration and anxiety that occasionally could result in aggressive behaviour.

Alexander (47) also expressed a rare individualistic viewpoint which proved to be problematic in the relationship with his wife who was giving priority to the collectivist rules.

> *…But my wife creates pressure out of thin air – for instance, we have to visit the parents every weekend, we have to help them make pickles and jam for the winter and to do other things around the house. For God's sake, I do not even eat jam or pickles and I want to spend the weekend playing tennis, but my wife is having none of it and says there is nothing worse than to feel old and ignored. We have a 20- year old son and she is still worried when he does not sleep at home or goes to the seaside with friends. I keep telling her that he is a sensible person, an excellent swimmer and an adult, so she has no reason to be like this, but she is just over protective. Her behaviour gets on my nerves…*

We can see the marked gender differences in familial expectations. According to Clancy and Dollinger (1993) women's self construal is more relational than men's. This participant was very particular about the small everyday activities that were causing him discomfort.

However, within a paragraph he completed a small journey from the light-hearted ‘pickles’ and ‘jam’ to bigger, more important things, indicating an inability to understand his wife’s interdependent nature.

- Death anxiety

Anxiety, originating in family relationships, in some participants was closely connected with death anxiety. This can be observed in the following paragraph from Anna’s (14) transcript.

> *...My great grandfather died two years ago and I cried a lot – I hate funerals and cemeteries. They give me bad dreams and I can’t sleep properly...*

A similar anxiety but derived from a different context could be found in Michael’s (15) transcript.

Death anxiety was commonly expressed by our adult participants too, but unlike with most adolescents whose fears seemed unfounded or hypothetical, they always talked from personal experience. This is evident in this paragraph from Gloria’s (36) interview.

> *…What is happening to this world? The other day me and an old friend from school sat down and started chatting about some people from our class. About 30% of them are no more – two of them have died in a car crash when we were in our early 20s, cancer and pneumonia killed another two, one has drowned in the sea trying to save his son and only recently an electric shock killed another one. It has happened during a storm – she was walking under the wires when the wind brought them down. Horrible death, such a waste. So, I sit down and think – we are only in our mid-thirties and so many tragedies already. School reunions are no longer these lovely, positive events I used to look forward to in the past. Death*

does scare me, especially when it happens to young people, who have not seen anything yet…

Gloria's death anxiety is different to the adolescents' fears in a number of ways. Although still young, fearful and deeply hurt by the premature tragedies around her, she accepts mortality. Maxfield et al. (2006) argued that as people got older frequent medical problems and loss of loved ones served as reminders of their own mortality. At the same time the Terror management theory (Greenberg et.al. 1986) asserts that awareness of the inevitability of death has a potent impact on human judgment and behaviour. They concluded that reminders of mortality increase young adults' self-esteem striving and defence of their cherished beliefs and values (i.e., their cultural worldviews). In addition, Kaneff (2002) reported that during communism there was a close connection between state ideology and the socially constructed 'natural' order. He suggested that nowadays the way in which people from rural Bulgaria talk about death reveals important changes: a reordering of the relationship between 'the individual' and the socially constructed 'natural' order, because the state is no longer such a strong mediating force in this relationship. As we have seen in our interviews with the adults, this added additional aspects to participants' death anxiety: they were able to talk freely about death after the changes, but felt less certain about being able to die with dignity themselves or provide adequate care and dignified funerals for their parents.

- Transnational families and anxiety

In Michael's (15) situation we can see not only the fear of losing a parent but also the emotional consequences of economic migration, a very commonly observed problem in rural Bulgaria.

> *...Dad is abroad like many dads from our area who have lost their jobs and he provides for us from Spain. I miss him so much and I am worried about him, because he works long hours and it is a very tough physical job. Dad has a heart condition and he should rest a lot, but it is not possible at the moment, because he wants me get decent education and to succeed. I am not going to disappoint him, I just hope he will come home alive and well. Losing him is my biggest fear, as there will be no one to protect me and mum and to look after us...*

A growing numbers of parents from low-income regions in Bulgaria are joining the global movement of workers moving to wealthier countries. A common feature of all such migrations is the creation of the so-called transnational family where children are geographically separated from one or both parents over an extended period (sometimes years). Many children and adolescents in Bulgaria (including people from my own surroundings) are currently growing up in the absence of their mother or father, or both. This family separation impacts on the health and well-being of children left behind as shown in a study by Graham and Jordan (2011). Children from transnational families were much more vulnerable and likely to have poor psychological well-being when compared to children from non-immigrant families.

- Manifestations of anxiety

Although causes for anxiety varied greatly and stemmed from unique family circumstances, economic reasons, body image issues, the adolescents appeared almost equally competent on the nature and symptomatology of anxiety. It is important to note that adolescent descriptions of anxiety varied significantly but many chose to place the emphasis on the physical manifestation of anxiety and the inability to exert control over anxiety symptoms. This metaphorical portrayal of anxiety by Donna (15) provides an interesting summary.

> *…It makes me feel very vulnerable and unable to control myself. Anxiety is an overwhelming feeling, it is like a bad smell – no matter how many times you wash your clothes, the smell still stays with you, I am trying to "wash my clothes" with positive emotions and I am trying to ignore bad things, but I cannot succeed…*

This extract from the interview with Stephen (17) also stresses on the overwhelming nature of anxiety.

> *…Restless and insecure. Filled with negative emotions and fears. Scared about everyone close to me and about what might happen tomorrow…*

And this extract from Anna's (14) interview adds another dimension to it.

> *…Anxiety is like a dry patch in my mouth. I feel it there when my dad is driving very fast on the motorway, it makes me feel dizzy…*

All of the above extracts show that adolescent participants are very much aware of the symptoms associated with anxiety and are able to attribute correctly certain physical and emotional states to this particular condition. According to Nesse and Finlayson (1996) these anxiety symptoms may not be sufficient to meet diagnostic criteria for an anxiety disorder but they can have a profound influence on the severity of and prognosis for the depressive illness. Some of the participants did show indications that both depression and anxiety were present as many elements such as predominant mood, sleep patterns, the needs for isolation and psychomotor signs met the criteria for depression. However, as previous research (Pennebaker, 1982) indicated, their almost perfect description of autonomic bodily responses could have been a result of schema thinking.

- Stigma in help-seeking/ Ignoring anxiety

Despite the accurate descriptions of anxiety in some adolescents, others expressed doubts that it was a real problem and viewed it a sign of weakness. Here is Diana's (17) view about anxiety.

> *…Anxiety is for people, who do not wish to change anything about their lives and prefer to moan and get depressed rather than put some work into things. Bad things happen to everyone and our fear of them will not change anything. In fact, if we waste energy to worry about things, we will have no power to deal with our problems. I agree that everyone is worried about something sometimes, but I prefer not to think about it much, otherwise it becomes worse…*

Ignoring anxiety seems to be a frequently used avoidant technique. It could be partially attributed to cultural issues or stigma associated with anxiety (Davies, 2000). These reasons could also determine the almost universal lack of trust in the medical profession in Bulgaria as illustrated in this extract from Donna's (15) interview.

> *…My doctor says I need to take hormones, but I am terrified that they will make me look like a man. I do not like going to the doctor's – they are usually rude and unsympathethic. One of them had a go at mum once several years ago – he said it was entirely her fault, because she has overfed me my entire life and he was not a magician to undo the damage now. Poor mum, she cried her eyes out, what a horrible man...*

Thom et al. (2004) argued that that trust is often a defining characteristic of patients' relationships with physicians and other care providers. The trust issues were recorded in Study 2, where the problem with trust arose, but here I was able to see exactly why the distrust occurred. These relationships are deeply personal and can be profoundly life-altering so they need to be of good quality. Maintaining and justifying trust between

doctors and patients is of crucial importance. Developing such relationship of trust is rarely possible in countries like Bulgaria noted for their long and mainly unsuccessful healthcare reformation riddled by corruption (Townsend, 2004)

- Alternative treatments for anxiety

The Bulgarian population is increasingly seeking alternative healing methods for both physical and mental health issues as evident by this extract from Martin's (16) interview.

> *…I am scared of flying too. My grandmother lives abroad and before we visit in the summer, I always ask my mum to do a bullet casting for me (Bulgarian superstition ritual, usually carried out in rural Bulgaria). It takes away my fear of flying. My mum says that when I was little, I was chased by a Caspian whipsnake and got really scared. I could not sleep well for weeks and then they decided to do the bullet casting. Apparently, it has helped me a lot, although I cannot remember the situation very well. My mum is also very fond of different herbal remedies and she gives me nice relaxation teas, which also help me a lot…*

Many interesting points emerge from this paragraph. The first one is the role of the mother – the person whom our participant trusts unreservedly when it comes to the positive effects of the alternative practices despite not being able to remember these effects himself. Alcock (2001) argued that our beliefs are, in essence, our expectations about the world around us. Our beliefs originated not only in personal experience, from logical analytical thought or from watching others but, more importantly in the cases of children and young people, from authority. Once children were being thought directly by their parents (or someone in a position of trust, e.g. teacher) about the magical

properties of a certain ritual or herbal remedy, they would rarely question its actual effect.

The so-called bullet casting (somewhere ‘bullet pouring’) ritual is obviously still performed frequently in some parts of Bulgaria. It was mentioned by three different participants from our sample, both adolescents and adults – a very surprising finding indeed, as for many people from urban areas the ritual is considered a part of folklore and modern Bulgarians are not aware that is it still performed in more traditional circumstances. (Roth and Roth, 1990). The bullet casting is a ritual performed by mystic healers for people (also children) who have experienced any sort of fear or anxiety. Molten lead is poured in icy water (a spell is cast during the process) in the presence of the person who has fears of anxiety and the old saying goes that the lead will take the shape of the personal fears (and the sufferer will get a miraculous cure from this ritual). In the past many Bulgarian people “cured” all sorts of illnesses attributed to fear with the help of this ritual (including nocturnal enuresis and speech defects such as stutter in children). The picture below presents this ritual as performed by an elderly lady in rural Bulgaria.

Picture 5.1. Bullet casting (leene na kurshum) in rural Bulgaria

In our adult participants the emphasis on distrust in mainstream medicine and pre-occupation with mystical practices and herbal medication for curing anxiety was also present. During the interview with Gloria, she talked about her own very disappointing experience with the health system when she was trying to become a mother.

> *…I have seen everything over the years – bad doctors, unsympathetic nurses, corrupted and heartless people, who get rich because they trade on other people's pain and dreams. I am so tired now and have no hope left. Our three in vitro fertilisations were also unsuccessful…*

According to Bodeker and Kronenberg (2002) in poorer countries up to 80% of the population relies on complementary and alternative medicine (homoeopathy, herbology, etc.) They argued that this was due to the general neglect of public health dimensions which left the people with a limited number of options. Where traditional medicine could not meet the needs of the population, people resorted to other methods.

- The role of communism as an anxiety source

The adults in our sample felt very strongly about the Communist rule and their own childhood and adolescence under the regime. Here is Mathilda's (47) vivid summary of this experience.

> *...All situations involving authority – now there is no respect whatsoever for authority, back then there was too much of it. So much in fact, that every time a teacher of someone older raised their voice or told me off, I just froze and did immediately what was asked of me. I did not question our mentality then, as I was too young to understand some things, but now I think that a lot of the things that make us nervous and restless now have their roots in the communist regime. It*

was accepted then, that everyone should be equal, despite the fact that some people clearly deserved more as they contributed more to the society. People from every little village in Bulgaria were moved to these huge industrial cities to work in factories and they were left in this kind of limbo – to work from Monday to Friday in the factory and then to go to their parents' villages in the weekend and to help them with agricultural work. Now these very same people are left with a tiny flat in an ugly concrete building, full of mould – too hot in the summer, too cold in the winter, and as many of them are unemployed they can't maintain this rubbish property and the decay is common everywhere. During the communism we were queueing for food and basic things such as soap and matches – we were only allowed a certain amount of them. Because of this people cannot avoid overspending now and getting a lot of things they don't need...

Mathilda (47) kept going backwards and forwards in this paragraph between memories and present consequences, from the general to the specific and firmly put the reasons for current anxiety in the past (she cited mainly economic reasons, the housing crisis and the process of urbanisation as problematic). She could not find any reasons for optimism at present either, a view which was shared by the vast majority of the interviewees.

Stoyan (54) had this very colourful memory of his adolescent years which has caused him a lot of pain and fear (most likely of a panic attack) and he was becoming very emotional when talking about it even after several decades have passed.

…When we were teens, we had to participate in these huge parades to honour the communist party. Loud, with deafening music, tidy rows, we were carrying huge flags and portraits of communist leaders. This was by far my worst time of the year – because I just had no other choice but to put up with the whole thing. I

remember that after such parade once, I had my heart in my throat, my ears were burning and I just had to sit beside the road as all I could see were black spots everywhere. I was throwing up until my lungs started to hurt. I wanted to hide, to be deaf, I wanted the ground to open and to swallow the whole masquerade, the noise. Very, very terrifying and painful experience...

His experience was terrifying for him in a number of ways. During these times, the Bulgarian psychiatry was heavily influenced by Soviet psychiatry. Under socialism, psychiatric disorders were attributed primarily to neurophysiologic or neurobiological origins. Psychosocial or psychodynamic etiology was denied or distorted in line with the political ideology of the Communist Party (Korolenko and Kensin, 2002). Psychiatry was a tool used for political purposes, many "enemies of the state" were institutionalised. Neurotic disorders were ignored by psychiatry or were regarded as the remnants of capitalism. In former socialist countries, psychodynamic psychotherapy was not common, and psychiatric patients were likely to experience social stigma. Stoyan's (54) main fear was that if any signs of mental health problems were detected, they will result in a long institutionalisation, a process which would have deprived him of any positive human qualities.

5.6.1. Limitations

The interview approach taken in this study allowed an in-depth exploration of adolescent and adult views on experiencing anxiety. It gave a good insight into their individual emotions as well as the causes and coping mechanisms. However, these findings should be acknowledged in the context of some limitations. Firstly, due to the transitional nature of human experience, it needs to be stated that the interviews capture just one moment in the life of our participants. Secondly, the sample, due to its small size cannot be representative for other areas of Bulgaria. Thirdly, the understanding and interpretation of

the questions were strictly individual and might have impacted the end results. This was partially addressed during the interview where any clarification issues were raised by the participants. Fourthly, the influence of my own perceptions and views formed a substantial part of the analysis. In the future, a larger sample might resolve this issue.

5.6.2. Directions for future research

Several of the findings from this study are worthy of further exploration. A follow-up interview in a year's time might give a better insight into the experience of anxiety for our participants. Conducting interviews with other age groups will also help to construct a comprehensive picture of anxiety across different generations in Bulgaria.

CHAPTER 6: THESIS SUMMARY AND CONCLUSION

6.1. Overview

This thesis examined anxiety and depression in a general population sample of Bulgarian adolescents and adults. Three studies took place: Study 1 explored prevalence and correlates (social support, self-construals) of anxiety and depression by gender and age in both age groups. Study 2 assessed their mental health literacy about depression and Study 3 analysed their unique personal experiences of anxiety. Because there are individual discussions for each study, what will be done here is a concise summary and interpretation of findings and a short discussion of research limitations and implications.

6.2. Summary and interpretation of findings

In terms of prevalence rates, the results from Study 1 showed that Bulgarian adolescents and adults prevalence rates of anxiety and depression are in line with results obtained in other cultures but the correlational relationships between variables are unique to our participants. The results from Study 2 indicated low mental health literacy rates about depression with adults being more profoundly affected by stigma in help-seeking. Results from Study 3 suggested that there were multiple additional contributing factors to anxiety and they were explored qualitatively.

The overall anxiety and depression levels are not a cause for concern. However, the significant correlational relationships between adolescent anxiety and emotional problems was indicative of the complex nature of this psychological condition and the way it impacted the lives of participants from both age groups. In a longitudinal study Roza et al. (2014) followed children with emotional problems for a 14-year period into

young adulthood and concluded that emotional problems were the most stable predictor for consequent anxiety disorder. The thesis showed that anxiety and depression indicators had a very complicated relationship with self-construal variables, particularly in adolescents. Considering the power dynamics, the complexity of adolescents social and peer relationship and the considerable difficulties they meet on the way to identity formation (Luyckx, 2006), these findings seem logical. Study 3 acknowledged even more components of this process by emphasising on the importance of physical appearance (which was equally salient to boys and girls), materialistic obsessions and the feelings of confusion and insecurity as causes for anxiety among the adolescents.

Adults expressed desire to blend in and do as others do and found fewer reasons for anxiety in self-image, but 'mourned' their lost future self and were anxious and pessimistic about the future. Koteskey et al. (1991) argued that adolescence in modern Western culture means that teenagers have lost much control of their lives to work, marriage, and education, losing out on community inclusion and becoming independent too soon. This individualistic aim for independence has started to emerge among the Bulgarian adolescents because they scored higher than adults on the independency sub-scale (Singelis, 1994). The adults, who have grown up in a collectivist society during the Communist rule, were still struggling to think of themselves as independent and were subconsciously trying to live by interdependent rules.

However, as the qualitative results from Study 3 showed, despite the higher score in Study the adolescents were still very heavily influenced by their parents' views on duty, obligation, appropriate behaviour and life choices (Kemmelmeier et al. 2003). The impact of feared social scenarios and punishments, acquired in childhood and adolescence, was evident in the adults' answers as they scored higher on social phobias and physical injury anxiety. Study 3 added texture and life to these childhood and

adolescent fears still held by the adults by examining memories of communist activities, financial hardship, punishments and censorship as causes for anxiety in the past.

The marked gender effects for prevalence rates observed for both age groups were similar to those observed in other countries. Girls and women were consistently showing more elevated rates of anxiety and depression than boys and men. Research literature attributes these findings to biological (Huerta and Brizuela-Gamino, 2002, Kaiser et al., 2013) and social (Hankin, 2007) reasons. My qualitative results gave insight into Bulgarian societal and parental expectations of adolescent girls which were often overwhelming and conflicting and caused a lot of family friction and subsequent anxiety. Girls were often expected to build a career, yet remain dutiful and take full responsibility for looking after parents (or in some cases, siblings), indicating that they needed to face just as demanding (if not more) social roles as adolescent boys. These demands were also observed in adult women, who remained interdependent and closely connected to their extended family (very often living under the same roof) but still worked full-time. Gregory (1999) argued that many mothers in fact need to work in the paid workforce to prevent their families from falling into poverty. The role of the family was heavily emphasised in both age groups as one of the main contributors to anxiety.

Mental health literacy about depression was quite low in both adolescents and adults. Their recognition rates were lower even than the rates given by people from collectivist cultures. Poor mental health literacy is determined by several factors: insufficient health education in Bulgarian schools, the complete lack of prevention and treatment of depression programmes in Bulgaria and the role of stigma in help-seeking. Research often describes depression as Western illness. Lutz (1985) argued that Western societies viewed reasons for depression as internal or biological whereas depression was viewed in situational and moral terms in non-Western societies. Therefore the Bulgarian participants were much more likely to give the depression description from the vignette

a more trivial explanation (e.g. minimal self-resolving problems) or to stigmatise the condition. Many respondents also expressed doubts about the seriousness of the condition and attributed symptoms to laziness and unwillingness to control emotions (Yang et al., 2014). The most prevalent view was that this condition was nothing more than the normal ups and downs of life. However, even among the small part of the sample who recognised depression correctly, there was a predominant lack of trust in the medical profession and unwillingness to seek help. This was more evident in the adolescents, who preferred to get help from mother. Interestingly, seeking help from mother is associated with internal locus of control (a concept mainly observed in Western societies) as stated by Shonert-Reichl and Muller (1995). This corresponds well with the higher adolescent scores for independency from Study 1. It could be argued that these findings show another aspect of a changing mind set in adolescents of modern Bulgaria who are slowly moving towards a more Western view of psychological problems. Although a larger number of adults recognised depression correctly, results indicated that they were more likely to be affected by stigma in help-seeking. Both age groups saw nothing wrong in having a few drinks to help problems related to depression, another finding that can be explained in a cultural context (Popova, 2007).

Findings from Study 3 completed the thesis by seeking out further explanations for attitudes and behaviours related to anxiety. They added a number of reasons for anxiety that have remained unexplored in the quantitative studies. Among these is the somatic aspect of anxiety which was omnipresent in the interview transcripts. It could be argued that both age groups expressed very good level of knowledge of anxiety somatic symptomatology when they were asked to describe their individual feelings. A number of stressors (Kessler et al., 1997) serving as trigger stimuli for anxiety emerged during the interviews (living arrangements, parental interference, work anxiety, conflicts with

extended families, the inability to fulfil one's dreams due to a number of restrictions, transnational family problem due to economic migration and death anxiety). Some unexpected reliance on ancient practices and alternative methods for treatment of anxiety also were recorded. Multiple components of the Self were identified – some were desired, other were unwanted, some belonged to the future and others were firmly placed in the past. They all pointed to one whole, completed Self unit, encompassing the meaning of life for every individual participant. When a conflict occurred between these components and parts of the self were lost, broken or rejected, there was a prerequisite for accumulation of anxiety.

6.3. Limitations of the thesis and directions for future research

Firstly, Study 1 and Study 2 employed cross-sectional design. A common problem with variable-orientated studies like these is the inability to establish causality. Maxwell and Cole (2007) argued that they can only record the end result of a relationship but cannot trace its dynamics. Cross-sectional studies are criticised for their incapacity to capture the relatively slow process of human development and the changes which occur with it. These limitations can be resolved with the help of longitudinal studies but the time and resources involved in the conduction of such studies. It would be interesting to explore further in the future some research findings, such as the correlation between emotional problems and anxiety in adolescents. Research shows such relationship is indicative for the future development of anxiety disorders (Rosa et al., 2014).

Secondly, the studies were conducted with randomly selected adolescent and adults and interviews were conducted with participants from a sub-sample of Study 1. In order to understand causality better and to get two comparative views of the same phenomena, it would be useful to schedule interviews for adolescents and their parents. Hudson and Rapee (2001) studied a sample consisting of clinically anxious children and non-clinical

children. After adjusting for the age and gender of the child, mothers of anxious children displayed greater and more intrusive involvement than mothers of non-clinical children. Mothers of anxious children displayed more negativism during the interactions than mothers of non-clinical children. The differences were consistent across three separate age groups and supported the view that overinvolved parenting style was associated with anxiety.

Thirdly, as previously mentioned, the Western measures (despite being translated and back-translated according to the strict requirements for cross-cultural research) reflect Western culture. The concept of 'anxiety' and 'depression' could hold completely different meanings for representatives of Western and Eastern culture (Proffer, 1996). In the future, all measures could be adapted to reflect the Bulgarian culture (e.g. St. John's wort is not a popular herbal remedy in Bulgaria and a large number of the general population are unfamiliar with antidepressants). It is possible that these answers were not chosen frequently simply because the participants were unaware of their uses.

Fourthly, the mental health literacy about anxiety has not been investigated. The comorbidity between anxiety and depression is a well-documented research finding (Wittchen et al. 2000, Carter et al., 2004). However it would be interesting to compare the levels of recognition between anxiety and depression scenarios.

Lastly, the factors identified in Study 3 require further investigation. Consequent interviewing combined with a quantitative measure (such as the Death Anxiety Scale by Thorson and Powell, 1992) can give these results a different perspective.

6.4. Implications of the thesis

This thesis obtained results through measures which were validated, respected and widely used internationally. This gives significance to the findings that is further

supported by the fact that despite numerous cultural, linguistic and healthcare differences, the results were in line to those obtained in other countries.

Before this thesis, anxiety and depression prevalence and correlates have not been examined in such a large number of participants from a Bulgarian population sample. Interpretative Phenomenological Analysis (a predominantly British qualitative measure) has not been applied to interpret qualitative data from Bulgaria. Now both the quantitative and qualitative contents of this large database can be used as a starting point for further development in the assessment of psychological disorders in Bulgaria.

6.5. Conclusion

This thesis collected and interpreted data from cultural settings where similar studies have not been conducted before. In that sense, it is a novel study, offering a detailed, but not fully comprehensive account of anxiety and depression in Bulgarian community settings. Its most important contribution is highlighting the issue of timely need for successful psychological assessment for anxiety and depression disorders combined with the acknowledgement of social and individual issues that play a contributing role to such assessments. Future research could help to resolve issues such as stigma in help-seeking and barriers to receiving appropriate treatment.

APPENDICES

Appendix I: Approval for ethics application (PSY 10/050)

Dear Ivelina,

I am happy to give confirmation of final SAEWG approval for ethics application (PSY 10/050) "An exploration of anxiety across different generations in Eastern Europe (Bulgaria)". The next stage is for Jan Harrison to forward the application to the School Ethics Committee (SEC), and then to the University Ethics Board (UEB) for ratification. Upon UEB approval, the research may commence.

I am attaching the final SAEWG report of approval to this email together with the final set of documentation for Jan Harrison's records. Please note that Jan has yet to check through the documentation herself and it is therefore possible that she will identify minor formatting corrections that I may have missed. Please also be aware that a couple of points relating to the research have been flagged up in the attached report for further consideration by the SEC.

Best wishes,

Mandy

(Chair, Psychology SAEWG)

Amanda Holmes, PhD

Principal Lecturer

School of Human and Life Sciences

Roehampton University

Holybourne Avenue

London SW15 4JD

++44 (0)20 8392 3784

Appendix II: Report of the Psychology Subject Area Ethics Working Group

School of Human and Life Sciences
Roehampton University

Report of the Psychology
Subject Area Ethics Working Group

Reference Number	PSY 10/ 050
Applicant(s)	Ivelina Tsocheva
Title of Application	An exploration of anxiety across different generations in Eastern Europe (Bulgaria)
Members of Working Group Present	Dr. Mandy Holmes (Chair), Jan Harrison (Ethics Administrator)
Date	30.4.10

Recommendation of the Psychology Subject Area Ethics Working Group to the School Ethics Committee:

Please tick:

(/) (1) The research may proceed as described.
( ) (2) The research may proceed subject to the conditions listed below being implemented.
( ) (3) The research may not proceed: a resubmission is required taking note of the points listed below.
( ) (4) The research may not proceed for the time being: the proposal has been referred for further ethical scrutiny - wait for further instructions.

Comments for the School Ethics Committee (applicant to ignore):

I would like to draw attention to the conditions and responses highlighted below in red (no. 2 and 14). I believe these points may need some further consideration.

The applicant has been notified that she will need to activate her Roehampton email address for the purposes of this postgraduate research. Her current email address is to be replaced with an appropriate Roehampton address on all correspondence

Comments for the University Ethics Board (applicant to ignore):

The UEB is requested to confirm that appropriate insurance cover is in place as the project is taking place overseas.

Conditions:

Ethics application

1. Section 2 should contain a paragraph in which ethical issues relating to the project are identified and discussed. See points 2 to 9 below for examples of what should be included.
   Paragraph about Ethical issues included in Section 2 above References.
2. In Section 2, more information is required as to the nature of the themes that will be explored and questions that will be asked in the follow-up qualitative interviews. (If it is not possible to provide sufficient detail at this stage, we may ask for a re-submission of the ethics application for this aspect of the research at a point in time when such information can be provided.)
   Pnenomenology allows the researcher to capture qualitative data in its richness without prejudging or assuming particular outcomes. Therefore, interviews will not be structured and participants will be invited to explain in their own words the feeling of anxiety with minimal intervention from researcher's part (How does your anxiety make you feel?) The path, drawn by the interviewee will be followed by the researcher, and her only role will be to ask for as many details as possible (Can you tell me more about this, please?) considering the participant's wishes (This paragraph is added to Section 2)

3. Given that sensitive issues relating to a person's experience of anxiety will be covered in the questionnaire and also raised in the follow-up interview, there should be some consideration of how the researcher will respond if the participant becomes upset. In the risk assessment form, it is stated that there will be appropriate support (access to counselling or alternative support), but more specific details are required in both Section 2 of the application and in the risk assessment form. For example, will the support come in the form of contact details for support groups on the debrief form, or will opportunities for more immediate access to counselling be arranged? Opportunities for immediate support, for example, from teachers or counsellors in schools for children who may become upset might be important in this instance. Finally, does the interviewer/researcher have any relevant training or experience that would equip her to deal with potentially difficult situations during an interview? (It is assumed that the participant's native language is Bulgarian and so limitations to successful communication should not be a point of concern – please confirm.)
   Risk assessment form has been corrected – more items have also been included on support and safety

1. Successful comminication with participants and appropriate interview training: researcher's mother tongue is Bulgarian. The researcher also has previous experience with interviewing on sensitive issues among people in Bulgaria (e.g., substance abuse and crime)

2. Sensitivity of explored themes: participants will be informed that they can withdraw at any time if they feel uncomfortable; assistance will be offered both as contact details with appropriate support organisations and immediate support from the school psychologist who will be informed of the nature of the research and asked for co-operation
(These items were added to the Ethical issues Paragraph)

3. Section 2, consideration should be given to the secure storage of audio data and the preservation of anonymity of such data as far as is practicable (e.g., by ensuring that recorded data stored on computer files using ID numbers is cross-liked to a separate database containing participants' names – see below). Please provide details.

Secure storage of data and anonymity – Safe Data Storage Limited software will be purchased – it fully encrypts the data and is password protected. Consent forms will be kept separately from questionnaires and audio data (Added to Ethical issues Paragraph)

4. Section 2: Please confirm that consent forms will be kept separately from questionnaire/audio/transcribed data to help preserve participant anonymity.
Confirmed in the Ethical issues Paragraph and added in the Debrief Forms.

5. Section 2 (and the risk assessment form): the safety of the researcher should be discussed, particularly as the researcher will be working alone with participants and will be in a different country. Please confirm that a member of staff from the host institution will always be present or in a nearby location during interviews. It is also important that the researcher notifies her supervisor (Professor Essau) and/or a trusted individual in the country in which the research is to be carried out of the dates and locations of appointments and ensures that an email is sent or phone call made at the end of each day of interviewing. If the nominated individual does not hear from the researcher, it is his/her responsibility to follow this up and to notify the supervisor.
Researcher's safety: Iinterviews will be conducted at the host institution's premises only and the teachers/employers who collaborate with the interviewer will be asked to check the progress of the interviewing process as regularly as possible. Furthermore, data collection (self-report questionnaires and interview) will be carried out during office hours of the institutions. Registration with a local police station will be arranged.
E-mails will be sent to the supervisor Prof Essau at the end of each day of interviewing.
(From the Ethical issues Paragraph) Items on researchers' safety added to the Risk Assessment Form.
MH 17.5.10: Thank you for adding this section to the ethics form – this is clearly presented and I am happy with your response. Unfortunately, these points still need to be a little clearer in the risk assessment form (simply because it is a standalone document). It would probably be fine to copy and paste the text above into the relevant box in the risk assessment form. Apologies for the need for this repetition.

6. Section 2: It is clear from the letters of invitation that 50 euros is being offered to teachers and employers. Please provide a brief justification for this – we need to be assured that the amount is appropriate as a gratuity (i.e. to cover reasonable expenses) and is not an 'inducement' to participation.
Incentives for teachers/employers: 50 euros for covering the time spent to collect the parental consent forms (teachers), arranging appointment times and booking rooms (teachers/employers), checking the interviewing process (teachers/ employers) and the employee's wages for one hour for questionnaires + individual interviewing (The average hour wage in the Private sector in Bulgaria for 2009 is 3 Euros) (Ethical Issues Paragraph)

MH 17.5.10: I have made a few small changes to the first couple of lines of this paragraph and would be grateful if you would replace the relevant lines in the ethics form with the following:

7. Gratuity for teachers/employers – 50 euros for covering reasonable expenses, such as the time spent to collect the parental consent forms (teachers), arranging....etc.

8. Section 2: Presumably the questionnaires and all other documentation will be translated into Bulgarian. Please provide details of how this will be done and the checks that will be in place to ensure that the translation is correct.
Translation – documents will be translated into Bulgarian by the researcher (a native speaker) and back-translated into English by a psychology graduate. This is the recommended and most commonly used procedure for cross-cultural research.
(Ethical isssues Paragraph)

9. Section 2: Please confirm the length of time needed for questionnaire completion and the qualitative interviews. We wondered whether adolescents would really be able to complete the questionnaires in 30 minutes as indicated on consent forms. Would 40-50 minutes be more realistic?
Length of questionnaire completion/interviewing – 30 minutes (on average) for questionnaire completion is realistic, as shown by pilot research with 6 participants (3 in each age group). Individual interviewing will also be completed in 30 minutes. (Ethical Isssues Paragraph)

10. Section 3: it is mentioned that people can give their names if they wish to be contacted for the qualitative interview. A few details are required to indicate how this personal identifying information will be stored and how it may be cross-linked with pseudonyms and/or ID codes.
If they decide to provide their real names, these will be kept separately from audio data and questionnaires in separate storage units. The software used will ensure that personal details are hidden –these could be obtained only by the researcher after typing in a specific code. The names will not be used in publications, pseudonyms will be used for interviewees.(Added to Section 3)

11. Section 3: please provide a few more details about the recruitment process. How will schools and companies be selected? How many will be approached?
Two hundred and fifty 13 to 17-year olds and two hundred and fifty adults 35 to 50 year olds will be recruited from various high schools, colleges and employment companies in Bulgaria. They will be randomly selected from a telephone directory book for Central and Northern Bulgaria. About 20 schools and companies will be approached initially.(Added to Section 3)

12. Section 3, please indicate how participants can withdraw their data retrospectively (as indicated on consent forms).
They will be informed that they can withdraw retrospectively from the study by contacting the researcher directly and ask for their data to be erased from the research files. Data already used in completed studies that has been published cannot be withdrawn, however, it will not be used in future research.(Added to Section 3)

13. Section 5: The statement "The data collection is anonymous" should be qualified as it is clear that full anonymity cannot be guaranteed in the case of follow-up interviews.
The statement was left out from Section 5 and replaced with: The data collection is confidential. Published results will comprise data derived from descriptive and inferential statistical analyses and only overall results and data (no individual data) will be published. Pseudonyms will be used in the publication of interview samples.

Consent forms

14. More detail is required on the second part of the study. For example, the statement that the interview will be about "anxiety experience" should be expanded to provide more information as to the nature of possible themes that may be explored in the interview and how long the interview is likely to last. It should also be mentioned that audio recordings will be made of interviews. There should be reference to the secure storage of audio recordings and transcripts and assurances of confidentiality and reference to the limits of anonymity (i.e. the identity of participants will be known to the researcher only, and all data will be stored using anonymous identifiers – i.e., ID codes or pseudonyms).
The participants are asked to explain how they feel when they are anxious. The interviews will be audio recorded and securely stored. The data will be protected by encryption software and only the researcher will know the true identity of the participant, accessible through an ID code. Samples of interviews will be published without any identifying information (i.e., names, locations and other details).The questionnaires will also be kept confidential and only be used for research purposes.(Added to the Consent form)

15. We can see that some information has been provided as to how a participant may go about withdrawing their data, but please mention also that they would need to contact the investigator directly in order to do this. It should also be stated that information that has already been used in a completed study or publication may not be withdrawn, although it will not be used in future research.
Participants will be informed of their right to withdraw from the study at any time, including retrospectively. They will further be informed that should they wish to withdraw from the study, they are asked to contact the researcher directly, and to quote the ID number provided them on the Debrief Form. In this way, the researcher will be able to identify their data and erase it

from the files. Furthermore, information already used in any publication may not be wtihdrawn, although it will not be used in future research (Added to the Consent form)

MH 17.5.10: Thank you for your response and for inserting this text in the adolescent and adult consent forms, but I think an equivalent paragraph will need to be added also to the parental consent form.

16. If audio recordings and/or written transcripts (or samples of these) are to be published or shared with other professionals (e.g., others involved in the research), please make this clear in the consent form and also emphasise that any such information will be presented WITHOUT identifying information. Thus, pseudonyms will be used for names and locations, and any other identifying details will be changed. If audio recordings and written transcripts are to be used in any other way (e.g., public presentations to non-scientific groups; recordings placed on a website, etc.), all relevant details should be provided in the consent form.
Samples of interviews will be published without identifying information (names, locations and other details).The questionnaires will also be kept confidential and only be used for research purposes. (Added to the Consent Form)

17. The Yes / No options underneath the first 3 points and the 4th point of the consent statement can be deleted as the participant's signature at the end of the consent form is sufficient. It will therefore be necessary to change the wording of the 4th point to: "I understand that the data will be stored in a secure location for at least 10 years." (Please note that the Roehampton University's policy on data storage has recently changed to a retention period of 10 years – the last line of p.11 in ethics application should be amended accordingly.)
YES/NO options have bee deleted. "6 years data storage" has been changed to 10 years on all documents.

18. Please provide full contact details not only for the Dean of School, but also for your Director of Studies, and also make reference to your DoS as follows "..if you would like to contact an independent party please contact the Dean of School or Director of Studies. (The DoS contact details should also be provided on letters of invitation and debrief forms.)
Details for Professor Essau have been added on all documents.

MH 17.5.10: As far as I can tell, the above sentence "...if you would, etc." has only been added to the parental consent form and not the other two consent forms. There are also some formatting issues that need to be rectified, i.e., presentation of correct addresses and use of single spacing rather than double spacing. What I suggest for each consent form is the following – please insert after each consent statement:

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Ivelina, for your own contact details, which appear before the consent statement, please use the following format :

Investigator Contact Details:
Miss Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD.

Please also ensure that the addresses are single spaced and as above on the debriefing forms and letters of invitation as well.

19. Please add a sentence to the effect that participants will be given a copy of the consent form to retain.
The following sentence was added: You will be given two consent forms to sign – one you need to return to the researcher and the other one is for you to retain.

MH 17.5.10: Please ensure that this has been added to each consent form.

Debriefing forms

20. Please provide a debriefing form for parents.
Debriefing form for the parents is written.

Letters of invitation

21. The Yes/No options at the end of the letters can be deleted – the name and signature are sufficient.
YES/NO options deleted

22. Letter to the teacher – the consent statement will need to be reworded as it currently reads as though teachers are providing consent for themselves to be participants rather than their pupils. In fact, we wondered whether a separate letter for teachers is needed at all, given that there is already a letter for head teachers.
I have reconsidered and I will not provide a letter to the Teacher.

Risk Assessment

23. See points 3 and 6 above.
Risk Assessment form amended accordingly.

Minor conditions

24. Please amend the format so that the logo and title at the bottom of the instruction page are at the top of page 1. Please also move the office use only box to the top of page 1. The format of P3 also needs to be amended slightly so that the final references appear correctly.
Title and logo appear at the top of Page 1. All references are now visible.

25. Please supply reference numbers and UEB dates of approval for the previously approved applications indicated in Section 2 of the ethics application. The intergenerational anxiety project (first one listed) was ref PSY 08/018, approved by the UEB on 7.1.10, but the other two we appear to have no record of. If they did not receive final UEB approval, please delete them.
I have kept the first study listed, as Prof Essau could not remember the Ref. Numbers for the other two projects. Please, note that 3 of the questionnaires listed for my project were used in this study.

26. The spacing on the consent forms should be adjusted in order that the consent form spans 2 pages rather than 3-4.
Consent forms have now been adjusted to two pages.

27. Please ensure consistency of the Roehampton address on all documentation, i.e.: School of Human and Life Sciences, Roehampton University, Whitelands College, Holybourne Avenue, London SW15 4JD, England, followed by the appropriate Roehampton phone number and email address.
Addresses on all documents consistent.

28. P. 5 of ethics application – please add 'CES-DC' to questionnaires for adolescents (no. 6?).
It has been added and referenced accordingly.

29. Please paginate all consent forms, debrief forms, and letters of invitation.
All documents paginated.

30. Please delete "Ethics Board" from title of all letters of invitation, consent forms and debrief forms.
Deleted from all documents.

31. On all documentation: School of Human and Life Science – should be School of Human and Life *Sciences*
It has been checked and amended where necessary.

32. Letters of invitation, para 2: please change "A Sample" to "a sample" and "questionnares" to "questionnaires". Please also amend the sentence including the words "to ask participation" to "to ask for their participation." Please change "I will contact you about it in the future" to "I will make further contact with you about this in the future." Letter to teachers, p.2: please change "A" to "a" when mentioning leaving the forms. Please also amend second bullet point to "justify their decision".
All corrections have been done.

33. Consent forms: para 3 – please change "form" to "forms". Consent form for parents: when mentioning the right to withdraw, please amend wording to include the fact that the child can withdraw him/herself from the study, and the parent/guardian can also ask for their child to be withdrawn from the study.
Changed to plural. Sentence on withdrawal added to Parental Consent Form.

34. Debrief forms – space needed for participant number on the Adolescents form.
Participant number space added to Adolescent Consent Form.

17.5.10 – MH raised a final point about the use of the applicant's personal phone number across all documentation. The applicant replied as follows:
As I do not have an office number at RU (I am a part-time PhD student), this is the only contact number that I can provide (I have considered it a better option than providing my landline number). I am also considering to purchase a Bulgarian SIM-card during my stay for fieldwork there to ease the communication.

Name/ Position: Dr. Mandy Holmes, Chair, Psychology SAEWG

Date: 18.5.10

Appendix III: A letter to the Head Teacher +Permission Form

Roehampton University London

A letter to the Head teacher

Dear Headteacher,

Title of Project:

An exploration of anxiety across different generations in Eastern Europe (Bulgaria)

I am based in the School of Human and Life Science, Roehampton University, currently conducting a study as a part of my doctoral dissertation which seeks to explore a range of factors related to anxiety in adolescents and adults in Bulgaria. In particular, I want to: (1) compare the type of objects/situations that adults and adolescents are most afraid of (2) compare anxiety level in two generations in Bulgaria; and to (3) compare specific factors that are linked to anxiety across generations.

For this purpose, I am recruiting adolescents from different schools and colleges across Bulgaria. I am kindly asking for your permission to carry out some research work within your school premises. The children will be given a set of questionnaires, which will take a total of about 30 minutes to complete (A Sample of the questionnares is provided with this letter).

Written consent will be obtained from their Parent/ Guardian and from the children prior to research.

These questionnaires will be used to assess (a) the type of situations and objects that people are afraid of, (b) how people feel when they are anxious, (c) what the other family members or friends may do when the child feels sick, (d) major life events the child may have experienced within the past 12 months, and (e) their age, gender etc. If the parents provide their permission, we will keep a record of their names too – these will only be used to establish contact with them to ask participation at a later stage of this research project.

A second part of this research will take place at a later stage, when a few of the children who have taken part in the first stage, will be selected randomly for individual interviewing on anxiety experience. I will make further contact with you about this in the future.

Otherwise, the questionnaires will be completed anonymously. The questionnaires will also be kept confidential and only be used for research purposes.

If you are happy for me to carry out the study at your school, I would be most grateful if you could please kindly complete and return the consent letter attached.

The children will complete the questionnaires at a specific time, date, and a room in the school as agreed by his/her teacher and I will administer the questionnaires. I have been Criminal Records Bureau (CRB) checked.

If you have any further questions or would like to know more about our research, please feel free to contact me.

Yours sincerely,

Miss Ivelina Tsocheva

Investigator' Contact Details:
Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

1. I understand that research work will take place in (Name of School) with participants who have provided written consent (parental and individual)

2. I agree to grant access to the school to Miss Ivelina Tsocheva to (Name of School) for research purposes

3. I understand that all personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

Name.....

Signature.....

Date.....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:

Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:

Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Appendix IV: A letter to the Employer + Permission Form

Roehampton University London

A letter to the Employer

Dear Employer,

Title of Project:

An exploration of anxiety across different generations in Eastern Europe (Bulgaria)

I am based in the School of Human and Life Science, Roehampton University, currently conducting a study as a part of my doctoral dissertation which seeks to explore a range of factors related to anxiety in adolescents and adults in Bulgaria. In particular, I want to: (1) compare the type of objects/situations that adults and adolescents are most afraid of (2) compare anxiety level in two generations in Bulgaria; and to (3) compare specific factors that are linked to anxiety across generations.

For this purpose, I am recruiting adolescents from different schools and colleges and adults from different employment companies across Bulgaria. I am kindly asking for your permission to carry out some research work within your employment premises. The participants will be given a set of questionnaires, which will take a total of about 30 minutes to complete (a sample of the questionnaires is provided with this letter).

Written consent will be obtained from participants prior to research.These questionnaires will be used to assess (a) the type of situations and objects that people are afraid of, (b) how people feel when they are anxious, (c) what the other family members or friends may do when they feels sick, (d) major life events they may have experienced within the past 12 months, and (e) their age, gender etc. If the participants provide their permission, we will keep a record of their names too – these will only be used to establish contact with them to ask participation at a later stage of this research project. The name of your employment company will not be disclosed in any form.

A second part of this research will take place at a later stage, when a few of the participants who have taken part in the first stage, will be selected randomly for individual interviewing on anxiety experience. I will make further contact with you about this in the future.The questionnaires and interviews will also be kept confidential and only be used for research purposes.

If you are happy for me to carry out the study at your premises, I would be most grateful if you could please kindly complete and return the consent letter attached.

The participants will complete the questionnaires at a specific time, date, and a room in the company as agreed by you and me and I will administer the questionnaires.

As a token of my appreciation for your help, a 50 euro high street voucher will be provided.

If you have any further questions or would like to know more about our research, please feel free to contact me.

Yours sincerely,

Miss Ivelina Tsocheva

Investigator' Contact Details:
Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

1. I understand that research work will take place in (Name of Company) with participants who have provided individual written consent

2. I agree to grant access to the premises of (Employment Company) to Miss Ivelina Tsocheva for research purposes

3. I understand that all personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

Name:.....

Signature.....

Date.....

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Appendix V: A letter to the parent

Roehampton University London

A LETTER TO THE PARENT

Dear Parent/ Guardian,

I am based in the School of Human and Life Science, Roehampton University, currently conducting a study as a part of my doctoral dissertation which seeks to explore a range of

factors related to anxiety in adolescents and adults in Bulgaria. In particular, I want to: (1) compare the type of objects/situations that adults and adolescents are most afraid of (2) compare anxiety level in two generations in Bulgaria; and to (3) compare specific factors that are linked to anxiety across generations.

For this purpose, your child will be given a set of questionnaires, which will take a total of about 30 minutes to complete.
These questionnaires will be used to assess (a) the type of situations and objects that people are afraid of, (b) how people feel when they are anxious, (c) what the other family members or friends may do when your child feel sick, (d) major life events your child may have experienced within the past 12 months, and (e) their age, gender etc. If you give your permission, we will keep a record of their names too – these will only be used to establish contactif you give your permission for your child to participate in the second stage of this research project. It consists of individual interviewing about anxiety experience (how does your child feel when anxious) and will take place at your child's school also.

Otherwise, the questionnaires will be completed anonymously, which means that your child's name will not be requested. The questionnaires will also be kept confidential and only be used for research purposes.If you are happy for your child to participate in our study, I would be most grateful if you could please kindly complete and return the consent letters attached.

Your child will complete the questionnaires at a specific time, date, and a room in the school as agreed by his/her teacher and I will administer the questionnaires. I have been Criminal Records Bureau (CRB) checked. You are free to withdraw permission for your child's participation at any time, without giving a reason.

If you have any further questions or would like to know more about our research, please feel free to contact me.

Yours sincerely,

Miss Ivelina Tsocheva

Investigator' Contact Details:

Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD

Tel: 020 8392 3647 Tel: 020 8392 3617
Email:c.essau@roehampton.ac.uk Email:m.barham@roehampton.ac.uk

Some examples of questions to be used in this study: For adolescents questionnaires

1. I worry about things
□ Never □ Sometimes
□ Often □ Always

2. I am afraid of being in small closed places, like tunnels or small rooms
□ Never □ Sometimes
□ Often □ Always

3. It's very hard for me to concentrate on a difficult lesson, if there is a lot of noise in the class
□ Almost never □ Sometimes
□ Often □ Always

□ Never □ Seldom (once or twice a year)
□ Occasionally (3-6 time a year) □ Often (more than 6 times a year)

4. I try to be nice to other people. I care about their feelings
□ Not True □ Somewhat True □ Certainly True

5. They cheer you up when you feel low
□ Not at all □ Only a little □ Quite a lot □ A great deal

Appendix VI: Consent form Adolescents

PARTICIPANT CONSENT FORM

Roehampton University London

(Adolescent Consent)

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe(Bulgaria)

Brief Description of Research Project:

This study aims to: (1) compare the type of objects/situations that adolescents and adults are most afraid of; (2) compare anxiety level in two generations across Bulgarian population and to (3) investigate and compare specific factors that are linked to anxiety across generations.

For this purpose, you will be asked to complete a set of questionnaires, which will take a total of about 30 minutes to complete.

The questionnaires will be completed anonymously, unless your parents have provided written permission for you to disclose your name and you want to take part in our second stage interviewing. The questionnaires will also be kept confidential and only be used for research purposes. Signed consent forms will be kept separately from all other data. You will be given two consent forms to sign – one you need to return to the researcher and the other one is for you to retain.

The second part of this study will take place at a later stage – it will consist of individual interviewing about anxiety experience. You will be asked to explain in your own words what anxiety feels like to you. The interviews will be audio recorded and securely stored. The data will be protected by encryption software and only the researcher will know the true identity of the participant, accessible through a private code. Samples of interviews will be published without identifying information (names, locations and other details).

You have a right to withdraw from the study at any time, including retrospectively. Should you wish to withdraw please contact the researcher directly, quote the ID number provided to you on the Debrief Form so that the researcher will be able to identify your data and erase it from the files. Please note that information already used in a completed study or publication may not be wtihdrawn, although it will not be used in future research.

Investigator' Contact Details:

Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968 445031
Email: tsochevi@roehampton.ac.uk

Consent Statement:

1. I agree to participate in this project.

2. I am aware that I can withdraw from this study at anytime without needing to justify my decision.

3. I understand that all personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

4. I understand that the information which I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings.

5. I understand that the data will be stored in a secure location for 10 years.

Name ……

Signature ……

Date ……

6. I agree for my name to be kept on record by the researcher, with my parent's permission, for the possibility of being contacted for the second part of this research (individual interview) at a future date.

Name ……

Signature ……

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Appendix VII: Consent Form Adults

Roehampton University London

PARTICIPANT CONSENT FORM

(ADULT CONSENT)

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe

Brief Description of Research Project:

This study aims to: (1) compare the type of objects/situations that adolescents and adults are most afraid of; (2) compare anxiety level in two generations across Bulgarian population and to (3) investigate and compare specific factors that are linked to anxiety across generations.For this purpose, you will be asked to complete a set of questionnaires, which will take a total of about 30 minutes to complete.

Please note that the questionnaires used in this study are not aimed at clinical evaluation. The questionnaires will be completed anonymously, unless you have stated specifically that you want to disclose your name. Your name will only be used to contact you for the second stage of this project – that is, individual interviewing about anxiety experience, if you want to take part in it. The questionnaires will also be kept confidential and only be used for research purposes. Signed consent forms will be kept separately from all other data. You will be given two consent forms to sign – one you need to return to the researcher and the other one is for you to retain.

The second part of this study will take place at a later stage – it will consist of individual interviewing about your anxiety experience. You will be asked to explain in your own words what anxiety feels like to you. The interviews will be audio recorded and securely stored. The data will be protected by encryption software and only the researcher will know the true identity of the participant, accessible through a private code. Samples of interviews will be published without identifying information (names, locations and other details).The questionnaires will also be kept confidential and will only be used for research purposes.

You have a right to withdraw from the study at any time, including retrospectively. Should you wish to withdraw please contact the researcher directly, quote the ID number provided to you on the Debrief Form so that the researcher will be able to identify your data and erase it from the files. Please, note that information already used in a completed study or publication may not be withdrawn, although it will not be used in future research.

Investigator' Contact Details:

Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968 445031
Email: tsochevi@roehampton.ac.uk

Consent Statement:

1. I agree to participate in this project.

2. I am aware that I can withdraw from this study at anytime without needing to justify my decision.

3. I understand that all personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

4. I understand that the information which I provide will be treated in confidence by the researcher and that my identity will be protected in the publication of any findings.

5. I understand that the data will be stored in a secure location for at least 10 years.

Name ……

Signature …….

Date ……

6. I agree for my name to be kept on record by the researcher for the possibility of being contacted for the second part of this research (individual interview) at a future date.

Name ……

Signature …….

Date ……

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Appendix VIII: Debrief Form Adolescents

Roehampton University London

Participant Number:

(for Adolescents)

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe (Bulgaria)

Brief Description of Research Project:

This research study seeks to explore anxiety in people from different generations (adolescents and adults) in Bulgaria. We want to investigate and compare differrent factors linked to anxiety across generations.

The questionnaires you have completed have been frequently used in many international studies. These questionnaires are used to assess (i) the type of situations and objects that people are afraid of, (ii) how people feel when they are anxious, (iii) what important others (family, friends, etc.)may do when you feel sick.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw from the study, contact us with your participant number (above) and your information will be deleted from our files.

If you have provided consent for taking part in the individual interviews about anxiety experience, you will be contacted shortly for an appointment.

If you are troubled or worried about any aspect of the study, or issues it may have raised, or wish to speak in confidence about anxiety, please feel free to contact any of the following agencies:

1. Anxiety BG: (details supplied)
   Specalises in helping people who suffer from anxiety and their families.

2. Young People Help Centre: (details supplied
   For young people, experiencing troubles and fear.

Should you have a concern about any aspect of your participation in this study, please raise this with me:

Investigator' Contact Details:
Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD

Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Thank you once again for your participation.
Miss Ivelina Tsocheva

Appendix IX: Debrief Form Adults

Roehampton University London

Participant Number:

DEBRIEF FOR ADULTS

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe

Brief Description of Research Project:

This research study seeks to compare the causes, symptoms and individual experiences of anxiety in people from different generations (adolescents and adults) in Bulgaria. We want to investigate and compare different factors linked to anxiety across generations.

The questionnaires you have completed have been developed, tested, and frequently used in numerous international studies. These questionnaires are used to assess (i) the type of situations and objects that people are afraid of, (ii) how people feel when they are anxious, (iii) what important others (family, friends, etc.)may do when you feel sick, and (iv) in what ways life events and situations may trigger anxiety.
Please note that none of these scales are aimed at any clinical evaluations, and we are looking at individual differences within healthy groups of adults.

If you have provided consent for taking part in the individual interviews about anxiety experience, you will be contacted shortly for an appointment.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw from the study, contact us with your participant number (above) and your information will be deleted from our files. If you are troubled or worried about any aspect of the study, or issues it may have raised, or wish to speak in confidence about anxiety, please feel free to contact any of the following agencies:

.

3. Anxiety BG: Specialises in helping people who suffer from anxiety and their families.

4. Anxiety Care: Specialises in consulting anxiety and depression sufferers.

Should you have a concern about any aspect of your participation in this study, please raise this with me:

Investigator' Contact Details:

Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Thank you once again for your participation.
Miss Ivelina Tsocheva

Appendix X: Debrief Form Parents

Roehampton University London

Participant Number:

DEBRIEF FOR THE PARENTS

(for their child's participation)

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe (Bulgaria)

Brief Description of Research Project:

This research study seeks to explore anxiety in people from different generations (adolescents and adults) in Bulgaria. We want to investigate and compare differrent factors linked to anxiety across generations.

The questionnaires your child has completed have been frequently used in many international studies. These questionnaires are used to assess (i) the type of situations and objects that people are afraid of, (ii) how people feel when they are anxious, (iii) what important others (family, friends, etc.)may do when they feel sick.

All data gathered during this study will be held securely and anonymously. If you wish to withdraw your child' s data from the study, contact the researcher directly with the number (above) and your information will be deleted from our files.

If you have provided consent for taking part in the individual intervews about anxiety experience, you will be contacted shortly for an appointment.

If your child is troubled or worried about any aspect of the study, or issues it may have raised, or wish to speak in confidence about anxiety, please tell them to feel free to contact any of the following agencies:

1. Anxiety BG: (details supplied)
   Specalises in helping people who suffer from anxiety and their families.

2. Young People Help Centre (details supplied)
   For young people, experiencing troubles and fear.
   Should you have a concern about any aspect of your child' s participation in this study, please raise this with me:

Investigator' Contact Details:
Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Thank you once again for your participation.
Miss Ivelina Tsocheva

Appendix XI: Parental Consent Form

Roehampton University London

PARTICIPANT CONSENT FORM

(Parent /Guardian consent for their child's participation)

Title of Research Project:

An exploration of anxiety across different generations in Eastern Europe (Bulgaria)

Brief Description of Research Project:

This study aims to: (1) compare the type of objects/situations that adolescents and adults are most afraid of; (2) compare anxiety level in two generations across Bulgarian population and to (3) investigate and compare specific factors that are linked to anxiety across generations.

For this purpose, your child will be asked to complete a set of questionnaires, which will take a total of about 30 minutes to complete.

Please note that the questionnaires used in this study are not aimed at clinical evaluation. The questionnaires will be completed anonymously, unless you have stated specifically that you are happy to disclose your child' s name (see below). Your child's name will only be used to contact you and your child at a later stage of our research project, which consists of individual interviewing of your child about their experience of anxiety. The questionnaires will also be kept confidential and will only be used for research purposes. Signed consent form will be kept separately from all other data. You will be given two

consent forms to sign – one you need to give to the researcher and the other one is for you to retain.

You have a right to withdraw from the study at any time – the child can withdraw his/herself and you can also ask for their withdrawal from the study. Should you wish to withdraw please quote the ID number provided to you on the Debrief Form so that the researchers will be able to identify your child's data and erase it form our files. Please, note that information already used in any publication may not be wtihdrawn, although it will not be used in future research.

Investigator' Contact Details:

Ivelina Tsocheva
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Telephone: 07968445031
Email: tsochevi@roehampton.ac.uk

Consent Statement:

1. I agree for my child to take part in this study.

2. I am also aware that my child can withdraw from this study at anytime without needing to justify his/her decision.

3. I understand that my child's personal data are held and processed in the strictest confidence, in accordance with the Data Protection Act (1998).

4. I understand that the information which my child provides will be treated in confidence by the researcher and that my child's identity will be protected in the publication of any findings

1. I understand that the data will be stored in a secure location for 10 years

Relationship to the child (i.e., parent, guardian or other) …….

Name ……

Signature …….

Date ……

2. I agree to disclose the name of my child in case the researcher wishes to contact me and my child for future research (i.e. for individual interviewing of my child).

Child's name …….

Please note: if you have a concern about any aspect of your participation or any other queries please raise this with the investigator. However if you would like to contact an independent party please contact the Dean of School (or if the researcher is a student you can also contact the Director of Studies.)

Director of Studies Contact Details:
Professor Cecilia Essau
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3647
Email:c.essau@roehampton.ac.uk

Dean of School Contact Details:
Michael Barham
Roehampton University
School of Human and Life Sciences
Whitelands College
Holybourne Avenue
London SW15 4JD
Tel: 020 8392 3617
Email:m.barham@roehampton.ac.uk

Appendix XII: Risk Assessment Form

Title: An exploration of anxiety across different generations in Bulgaria									
Risk Assessment No:	**Event / Activity:**				**Date Assessed:** **Review Date:**			**Assessor's Name:** **Assessor's Signature:**	
		Uncontrolled Risk				Residual Risk			
		Severity x Likelihood = Risk Rating				Severity x Likelihood = Risk Rating			
Hazard	To Whom				Control Risk by		L		Further Action Needed
Sensitivity of subject	Participants				Participants can withdraw at any time; immediate help (e.g. School psychologist) and support from organisations will be offered		1		
Successful communication/ appropriate interview training	Participants				RESEARCHER'S NATIVE LANGUAGE IS BULGARIAN AND PREVIOUS EXPERIENCE WITH INTERVIEWING ON SENSITIVE SUBJECTS GAINED IN BULGARIA (SUBSTANCE ABUSE, CRIME)		0		

Secure storage of data and anonymity	Participants				Safe Data Storage Limited will be used for data encryption, password protected. Consent forms will be kept separately from other data.		1		
Safety	Researcher				Interviews held at host institution premises at opening times, collaborators checking progress, daily updates via e-mail to Director of Studies, registering at local Police Station		1		

Severity			**Risk Matrix**				
HIGH	3	Fatality or major injury causing long-term disability			Likelihood		
MEDIUM	2	Injury or illness causing short-term disability	Severity		**H**		**L**
LOW	1	Other injury or illness			**9**		**3**
Likelihood					**6**		**2**
HIGH	3	Certain or near certain			**3**		**1**
MEDIUM	2	Reasonably	**Risk Rating**				

		likely		
LOW	1	Very seldom or never	6 - 9 HIGH RISK	Immediate action required to reduce risk
			3 - 4 MEDIUM RISK	Seek to further reduce risk
			1 - 2 LOW RISK	No action but continue to monitor

Appendix XIII: Questionnaires for Adolescents (English)

QUESTIONNAIRES FOR ADOLESCENTS
Spence Child Anxiety Scale

Please put a circle around the word that shows how often each of these things happen to you. There are no right or wrong answers.

	never	**Some-times**	**Often**	**Always**
1. I worry about things	0	1	2	3
. I am scared of the dark	0	1	2	3
. When I have a problem, I get a funny feeling in my stomach	0	1	2	3
. I feel afraid.	0	1	2	3
5. I would feel afraid of being on my own at home.	0	1	2	3
6. I feel scared when I have to take a test	0	1	2	3
7. I feel afraid if I have to use public toilets or bathrooms	0	1	2	3
8. I worry about being away from my parents	0	1	2	3
9. I feel afraid that I will make a fool of myself in front of people	0	1	2	3
10. I worry that I will do badly at my school work	0	1	2	3
11. I worry that something awful will happen to someone in my family	0	1	2	3
12. I suddenly feel as if I can't breathe when there is no reason for this	0	1	2	3
. 13. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	0	1	2	3
14. I feel scared if I have to sleep on my own	0	1	2	3
15. I have trouble going to school in the mornings because I feel nervous or afraid	0	1	2	3
16. I am scared of dogs	0	1	2	3
17. I can't seem to get bad or silly thoughts out of my head	0	1	2	3
18. When I have a problem, my heart beats really fast	0	1	2	3
19. I suddenly start to tremble or shake when there is no reason for this	0	1	2	3
20. I worry that something bad will happen to me	0	1	2	3
21. I am scared of going to the doctors or dentists	0	1	2	3
22. When I have a problem, I feel shaky	0	1	2	3
23. I am scared of being in high places or elevators	0	1	2	3
24. I have to think of special thoughts (like numbers or words) to stop bad things from happening	0	1	2	3
25. I feel scared if I have to travel in the car, or on a Bus or a train	0	1	2	3
26. I worry what other people think of me	0	1	2	3
27. I am afraid of being in crowded places (like shopping centres, the movies, buses, busy playgrounds)	0	1	2	3
28. All of a sudden I feel really scared for no reason at all	0	1	2	3
29. I am scared of insects or spiders	0	1	2	3
30. I suddenly become dizzy or faint when there is no reason for this	0	1	2	3
31. I feel afraid if I have to talk in front of my class	0	1	2	3
32. My heart suddenly starts to beat too quickly for no reason	0	1	2	3

33. I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	0	1	2	3
34. I am afraid of being in small closed places, like tunnels or small rooms	0	1	2	3
35. I have to do some things over and over again (like washing my hands, cleaning or putting things in a certain order)	0	1	2	3
36. I get bothered by bad or silly thoughts or pictures in my mind	0	1	2	3
37. I have to do some things in just the right way to stop bad things happening	0	1	2	3
38. I would feel scared if I had to stay away from home overnight	0	1	2	3
39. I feel happy about my life	0	1	2	3
40. I like to get up in the morning	0	1	2	3

Self-Construal Scale

Please circle the number (1 – 7) which best indicates how much you agree or disagree with the statements below.

If any of the questions are not applicable to you please leave blank.

	Strongly agree 7	**Agree 6**	**Slightly agree 5**	**Neither agree nor disagree 4**	**Slightly disagree 3**	**Disagree 2**	**Strongly disagree 1**
I have respect for the authority figures with whom I interact.	7	6	5	4	3	2	1
It is important for me to maintain harmony within my group.	7	6	5	4	3	2	1
My happiness depends on the happiness of those around me.	7	6	5	4	3	2	1
I would offer my seat in a bus to my professor.	7	6	5	4	3	2	1
I respect people who are modest about themselves.	7	6	5	4	3	2	1
I will sacrifice my self-interest for the benefit of the group I am in.	7	6	5	4	3	2	1
I often have the feeling that my relationships with others are more important than my own accomplishments.	7	6	5	4	3	2	1
I should take into consideration my parents' advice when making education/career plans.	7	6	5	4	3	2	1
It is important for me to respect decisions made by the group.	7	6	5	4	3	2	1
I will stay in a group if they need me, even when I'm not happy with the group.	7	6	5	4	3	2	1
If my brother or sister fails, I feel responsible.	7	6	5	4	3	2	1
Even when I strongly disagree with group members, I avoid an argument.	7	6	5	4	3	2	1
I'd rather say "No" directly, than risk being misunderstood.	7	6	5	4	3	2	1
Speaking up during a class is not a problem for me.	7	6	5	4	3	2	1
Having a lively imagination is important to me.	7	6	5	4	3	2	1
I am comfortable with being singled out for praise or rewards.	7	6	5	4	3	2	1
I am the same person at home that I am at school.	7	6	5	4	3	2	1
Being able to take care of myself is a primary concern for me.	7	6	5	4	3	2	1
I act the same way no matter who I am with.	7	6	5	4	3	2	1

I feel comfortable using someone's first name soon after I meet them, even when they are much older than I am.	7	6	5	4	3	2	1
I prefer to be direct and forthright when dealing with people I've just met.	7	6	5	4	3	2	1
I enjoy being unique and different from others in many respects.	7	6	5	4	3	2	1
My personal identity independent of others, is very important to me.	7	6	5	4	3	2	1
I value being in good health above everything.	7	6	5	4	3	2	1

Strength and Difficulties Questionnaire

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain or the item seems daft! Please give your answers on the basis of how things have been for you over the last six months.

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings			
I am restless, I cannot stay still for long			
I get a lot of headaches, stomach-aches or sickness			
I usually share with others (food, games, pens etc.)			
I get very angry and often lose my temper			
I am usually on my own. I generally play alone or keep to myself			
I usually do as I am told			
I worry a lot			
I am helpful if someone is hurt, upset or feeling ill			
I am constantly fidgeting or squirming			
I have one good friend or more			
I fight a lot. I can make other people do what I want			
I am often unhappy, down-hearted or tearful			
Other people my age generally like me			
I am easily distracted, I find it difficult to concentrate			
I am nervous in new situations. I easily lose confidence			
I am kind to younger children			
I am often accused of lying or cheating			
Other children or young people pick on me or bully me			
I often volunteer to help others (parents, teachers, children)			
I think before I do things			
I take things that are not mine from home, school or elsewhere			
I get on better with adults than with people my own age			
I have many fears, I am easily scared			
I finish the work I'm doing. My attention is good			

	No	Yes, minor difficulties	Yes-definite difficulties	Yes-severe difficulties
Overall, do you think that you have difficulties in one or more of the following areas: Emotions, concentration, behaviour or being able to get on with other people?				

If you answered 'YES', please answer the following questions about these difficulties:

How long have these difficulties been present?

□ Less than a month □ 1-5 months
□ 6-12 months □ Over a year

Do the difficulties upset or distress you?

□ Not at all □ Only a little
□ Quite a lot □ A great deal

Do the difficulties interfere with your everyday life in the following areas?

- Home Life □ Not at all □ Only a little □ Quite a lot □ A great deal
- Friendships □ Not at all □ Only a little □ Quite a lot □ A great deal
- Classroom Learning □ Not at all □ Only a little □ Quite a lot □ A great deal
- Leisure Activities □ Not at all □ Only a little □ Quite a lot □ A great deal

Do the difficulties make it harder for those around you (family, friends, teachers etc.)?

□ Not at all □ Only a little □ Quite a lot □ A great deal

Social Support

How much do you feel that people around you regularly support you?
Choose a number that best fits the question:

1=Not at all 2= Only a little 3=Quite a lot 4= A great deal

	Not at all	Only a little	Quite a lot	A great deal
They cheer you up when you feel low.	1	2	3	4
They console you when someone says nasty things to you.	1	2	3	4
When something good happens to you, they feel delighted.	1	2	3	4
When you don't know what to do, they take care of it.	1	2	3	4
They always listen hard to what you say.	1	2	3	4
If you don't do well on something, they comfort you wholeheartedly.	1	2	3	4
They notice at once when you are feeling bad and cheer you up.	1	2	3	4
They listen to you without a fuss when you speak of your worries or complaints.	1	2	3	4
They help you gently even if you make a mistake.	1	2	3	4
They congratulate you heartily when you achieve something.	1	2	3	4
They help you willingly when there is something you can't do alone.	1	2	3	4
They are generally well aware of your feelings.	1	2	3	4
They believe you at all times.	1	2	3	4
If they know you have a problem, they tell you what to do.	1	2	3	4
They fully understand your strengths and your faults.	1	2	3	4
They treat you very lovingly.	1	2	3	4

CES-DC

DURING THE PAST WEEK	Not At All	A Little	Some	A Lot
I was bothered by things that usually don't bother me.	3	2	1	0
I did not feel like eating, I wasn't very hungry.				
I wasn't able to feel happy, even when my family or friends tried to help me feel better.				
I felt like I was just as good as other kids.				
I felt like I couldn't pay attention to what I was doing.				
I felt down and unhappy.				
I felt like I was too tired to do things.				
I felt like something good was going to happen.				
I felt like things I did before didn't work out right.				
I felt scared.				
I didn't sleep as well as I usually sleep.				
I was happy.				
I was more quiet than usual.				

I felt lonely, like I didn't have any friends.				
I felt like kids I know were not friendly or that they didn't want to be with me.				
I had a good time.				
I felt like crying.				
I felt sad.				
I felt people didn't like me.				
It was hard to get started doing things.				

John is a 15 year old who has been feeling unusually sad and miserable for the last few weeks. He is tired all the time and has trouble sleeping at night. John doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He puts off making any decisions and even day-to-day tasks seem too much for him. His parents and friends are very concerned about him.

1. What, if anything, do you think is wrong with John?

_____

_____

2. If you had a problem right now like John, would you go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you go?

☐ Would seek help from BOTH parents ☐ Would seek help from mother

☐ Would seek help from father

☐ Would seek help from other person (specify): _____

☐ Would seek help from service (specify): _____

☐ Don't know

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident

☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop you from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about you ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐Thinking that nothing can help

☐ Concern about what other people might think of you seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify)

☐ Don't know

There are a number of different things a friend or family member could do that could possibly help John with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* for John's problem if a friend or family member were to do these things.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Listen to his problems in an understanding way	☐	☐	☐	☐	☐
2. Talk to him firmly about getting his act together	☐	☐	☐	☐	☐
3. Suggest he seek professional help	☐	☐	☐	☐	☐
4. Make an appointment for him to see a GP	☐	☐	☐	☐	☐
5. Ask him whether he is feeling suicidal	☐	☐	☐	☐	☐
6. Suggest he have a few drinks to forget his troubles	☐	☐	☐	☐	☐
7. Rally friends to cheer him up	☐	☐	☐	☐	☐
8. Ignore him until he gets over it	☐	☐	☐	☐	☐
9. Keep him busy to keep his mind off problems	☐	☐	☐	☐	☐
10. Encourage him to become more physically active	☐	☐	☐	☐	☐

There are a number of different people who could possibly help John with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to John's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐
3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counseling service	☐	☐	☐	☐	☐
5. A psychologist	☐	☐	☐	☐	☐
6. A psychiatrist	☐	☐	☐	☐	☐
7. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
8. A close family member	☐	☐	☐	☐	☐
9. A close friend	☐	☐	☐	☐	☐
10. Dealing with his problems on his own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for John's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

Do you think the following are likely to be *helpful*, *harmful* or *neither* for John's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Becoming more physically active	☐	☐	☐	☐	☐
2. Getting relaxation training	☐	☐	☐	☐	☐
3. Practicing meditation	☐	☐	☐	☐	☐
4. Having regular massages	☐	☐	☐	☐	☐
5. Getting acupuncture	☐	☐	☐	☐	☐
6. Getting up early each morning and getting out in the sunlight	☐	☐	☐	☐	☐
7. Receiving counselling	☐	☐	☐	☐	☐
8. Receiving cognitive-behaviour therapy	☐	☐	☐	☐	☐
9. Looking up a web site giving information about his problem	☐	☐	☐	☐	☐
10. Reading a self-help book on his problem	☐	☐	☐	☐	☐
11. Joining a support group of people with similar problems	☐	☐	☐	☐	☐
12. Going to a local mental health service	☐	☐	☐	☐	☐
13. Being admitted to a psychiatric ward of a hospital	☐	☐	☐	☐	☐
14. Using alcohol to relax	☐	☐	☐	☐	☐
15. Smoking cigarettes to relax	☐	☐	☐	☐	☐
16. Using marijuana to relax	☐	☐	☐	☐	☐
17. Cutting down on use of alcohol	☐	☐	☐	☐	☐
18. Cutting down on smoking cigarettes	☐	☐	☐	☐	☐
19. Cutting down on marijuana	☐	☐	☐	☐	☐

The next few questions are about things John might do to reduce his risk of developing the problem in the first place. If a young person did the following, do you think it would **reduce their risk** of developing a problem like John's?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Keeping physically active	☐	☐	☐	☐	☐
2. Avoiding situations that might be stressful	☐	☐	☐	☐	☐
3. Keeping regular contact with friends	☐	☐	☐	☐	☐
4. Keeping regular contact with family	☐	☐	☐	☐	☐
5. Avoiding sugary foods	☐	☐	☐	☐	☐
6. Not using marijuana	☐	☐	☐	☐	☐
7. Never drinking alcohol in excess	☐	☐	☐	☐	☐
8. Making regular time for relaxing activities	☐	☐	☐	☐	☐
9. Having a religious or spiritual belief	☐	☐	☐	☐	☐

The next few questions contain statements about John's problem. Please indicate how strongly YOU PERSONALLY agree or disagree with each statement.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
John could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
John's problem is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
John's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
John is dangerous (i.e., 'dangerous to others').	☐	☐	☐	☐	☐	☐
It is best to avoid John so that you don't develop this	☐	☐	☐	☐	☐	☐

problem yourself.						
John's problem makes him unpredictable.	☐	☐	☐	☐	☐	☐
You would not tell anyone if you had a problem like John's.	☐	☐	☐	☐	☐	☐

Please indicate what you think MOST OTHER PEOPLE believe. Please indicate how strongly you agree or disagree with the following statements.

	Strongly disagree	*Disagree*	*Neither agree nor disagree*	*Agree*	*Strongly agree*	*Don't know*
Most other people believe that John could snap out of it if he wanted.	☐	☐	☐	☐	☐	☐
Most people believe that John's is a sign of personal weakness.	☐	☐	☐	☐	☐	☐
Most people believe that John's problem is not a real medical illness.	☐	☐	☐	☐	☐	☐
Most people believe that John is dangerous.	☐	☐	☐	☐	☐	☐
Most people believe that it is best to avoid John so that they don't develop this problem themselves.	☐	☐	☐	☐	☐	☐

Most people believe that John's problem makes him/her unpredictable.	☐	☐	☐	☐	☐	☐
Most people would not tell anyone if they had a problem like John's.	☐	☐	☐	☐	☐	☐

The following questions ask how you would feel about spending time with John. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with John on the weekend?	☐	☐	☐	☐	☐
To work on a project with John?	☐	☐	☐	☐	☐
To invite John around to your house?	☐	☐	☐	☐	☐
To go to John's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with John?	☐	☐	☐	☐	☐

How likely is John's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
His own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way he was raised	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐
Bad luck	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to John's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to John's?

☐ Yes ☐ No ☐ Don't know

→ If YES:

- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: □ Christian: __ Catholic __ Protestant

__

Other: Please specify _____

□ Judaism

□ Buddhist

□ Muslim □ Hindu

□ Other: Please specify _____ □ None

5. How would you describe your ethnic origin?

WHITE: □ English □ Scottish □ Welsh
□ Irish □ British □ Other (please specify: _____)

MIXED: □ White and Black Caribbean □ White and Black African
□ White and Asian □ Other Mixed Background
□ All Mixed groups

ASIAN or ASIAN BRITISH: □ Indian □ Pakistani
□ Bangladeshi □ Other Asian background
□ All Asian groups

BLACK or BLACK BRITISH: □ Caribbean □ African
□ Other Black background □ All Black groups

CHINESE or Other Ethnic Group: □ Chinese □ Other ethnic group
□ All Chinese or Other groups

Middle Eastern (please specify: _____)

Thank you very much for your time !

Appendix XIV: Questionnaires for Adults (English)

QUESTIONNAIRES FOR ADULTS

Spence-Essau Anxiety Scale

Please put a circle around the word that shows how often each of these things happened to you. There are no right or wrong answers.

	never	**Some-times**	**Often**	**Always**
1. I worry that I will behave the wrong way and embarrass myself in front of others	0	1	2	3
. I am afraid of thunder, lightning or storms	0	1	2	3
. I suddenly feel as if I can't breathe or am going to pass out when there is no reason for this	0	1	2	3
4. I feel frightened of heights (e.g., standing at the edge of cliffs or balconies of tall buildings)	0	1	2	3
5. I have to keep checking that I have done things right (like the electricity is switched off, or the door is locked)	0	1	2	3
6. I feel afraid of giving speeches or speaking in public	0	1	2	3
7. I suddenly start to tremble or shake with fear for no reason	0	1	2	3
8. I have urges to do inappropriate things and find these difficult to control	0	1	2	3
9. I suddenly feel like I am in danger and that something terrible is going to happen to me	0	1	2	3
10. I take a very long time to do some things because they have to be done in a particular way	0	1	2	3
11. I worry about all sorts of different things	0	1	2	3
12. I feel anxious in situations where I am the centre of attention	0	1	2	3
13. I am afraid of flying on aeroplanes	0	1	2	3
14. I have to think special thoughts (like numbers or words) over and over to stop things from going wrong	0	1	2	3
15. I feel afraid if I have to start a conversation with someone I don't know	0	1	2	3
16. I find it difficult to stop worrying	0	1	2	3
17. I am afraid of closed place (e.g., caves, tunnels, or elevators)	0	1	2	3
18. I suddenly feel afraid of losing control or going crazy	0	1	2	3
19. I have to do some things over and over again (like washing my hands, cleaning, or putting certain things in order)	0	1	2	3
20. I feel tense, irritable or on edge	0	1	2	3
21. I feel afraid if I see blood	0	1	2	3
22. My heart suddenly starts to beat too quickly for no reason	0	1	2	3
23. I worry that I will become sick when I am out in public	0	1	2	3
.24. I get upset by bad or unpleasant thoughts or pictures that keep coming into my mind against my will	0	1	2	3
25. I feel afraid that I will make a fool of myself in front of other people	0	1	2	3
26. I feel afraid if I have to have an injection at the doctors or dentists	0	1	2	3
27. I have to do some things in just the right way to stop bad things from happening	0	1	2	3
28. I have difficulty getting to sleep or staying asleep most nights	0	1	2	3
29. I feel nervous when I am introduced to new people	0	1	2	3
30. I am scared of insects, spiders, birds, reptiles or mice	0	1	2	3
31. Thoughts or images keep coming into my mind that are shameful, frightening, violent or really strange	0	1	2	3
32. I am afraid of being in crowded places (like busy shopping centers, buses, fairgrounds)	0	1	2	3
33. I dislike using things that have been touched by other people or	0	1	2	3

animals (like public phones, public toilets, bus seats)				
39. I feel happy about my life	0	1	2	3
40. I like to get up in the morning	0	1	2	3

Self-Construal Scale

Please circle the number (1 – 7) which best indicates how much you agree or disagree with the statements below.

If any of the questions are not applicable to you please leave blank.

	Strongly agree	**Agree**	**Slightly agree**	**Neither**	**Slightly disagree**	**Disagree**	**Strongly disagree**
I have respect for the authority figures with whom I interact.	7	6	5	4	3	2	1
It is important for me to maintain harmony within my group.	7	6	5	4	3	2	1
My happiness depends on the happiness of those around me.	7	6	5	4	3	2	1
I would offer my seat in a bus to my professor.	7	6	5	4	3	2	1
I respect people who are modest about themselves.	7	6	5	4	3	2	1
I will sacrifice my self-interest for the benefit of the group I am in.	7	6	5	4	3	2	1
I often have the feeling that my relationships with others are more important than my own accomplishments.	7	6	5	4	3	2	1
I should take into consideration my parents' advice when making education/career plans.	7	6	5	4	3	2	1
It is important for me to respect decisions made by the group.	7	6	5	4	3	2	1
I will stay in a group if they need me, even when I'm not happy with the group.	7	6	5	4	3	2	1
If my brother or sister fails, I feel responsible.	7	6	5	4	3	2	1
Even when I strongly disagree with group members, I avoid an argument.	7	6	5	4	3	2	1
I'd rather say "No" directly, than risk being misunderstood.	7	6	5	4	3	2	1
Speaking up during a class is not a problem for me.	7	6	5	4	3	2	1
Having a lively imagination is important to me.	7	6	5	4	3	2	1
I am comfortable with being singled out for praise or rewards.	7	6	5	4	3	2	1
I am the same person at home that I am at school.	7	6	5	4	3	2	1
Being able to take care of myself is a primary concern for me.	7	6	5	4	3	2	1
I act the same way no matter who I am with.	7	6	5	4	3	2	1
I feel comfortable using someone's first name soon after I meet them, even when they are much older than I am.	7	6	5	4	3	2	1
I prefer to be direct and	7	6	5	4	3	2	1

forthright when dealing with people I've just met.							
I enjoy being unique and different from others in many respects.	7	6	5	4	3	2	1
My personal identity independent of others, is very important to me.	7	6	5	4	3	2	1
I value being in good health above everything.	7	6	5	4	3	2	1

Depression, Anxiety, and stress Scale - 21

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

I found it hard to wind down	0	1	2	3
I was aware of dryness of my mouth	0	1	2	3
I couldn't seem to experience any positive feeling at all	0	1	2	3
I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
I found it difficult to work up the initiative to do things	0	1	2	3
I tended to over-react to situations	0	1	2	3
I experienced trembling (eg, in the hands)	0	1	2	3
I felt that I was using a lot of nervous energy	0	1	2	3
I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
I felt that I had nothing to look forward to	0	1	2	3
I found myself getting agitated	0	1	2	3
I found it difficult to relax	0	1	2	3
I felt down-hearted and blue	0	1	2	3
I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
I felt I was close to panic	0	1	2	3
I was unable to become enthusiastic about anything	0	1	2	3
I felt I wasn't worth much as a person	0	1	2	3
I felt that I was rather touchy	0	1	2	3
I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
I felt scared without any good reason	0	1	2	3
I felt that life was meaningless	0	1	2	3

Berlin Social Support Scales

	Yes	No
1. There are some people who truly like me.		

2. Whenever I am not feeling well, other people show me that they are fond of me.		
3. Whenever I am sad, there are people who cheer me up.		
4. There is always someone thee for me when I need comforting.		
5. I know some people upon whom I can always rely.		
6. When I am worried, there is someone who helps me.		
7. There are people who offer me help when I need it.		
8. When everything becomes too much for me to handle, others are there to help me.		

John is a 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making any decisions. Even day-to-day tasks seem too much for him. This has come to the attention of John's boss who is concerned about his lowered productivity.

1. What, if anything, do you think is wrong with John?

_____

_____

2. If you had a problem right now like John, would you go for help?

☐ Yes ☐ No ☐ Don't know

2a) If YES, where would you go? _____

2b) How confident would you be in your ability to ask this (person/service) for help? Would you say…?

☐ Very confident ☐ Fairly confident ☐ Slightly confident

☐ Not confident at all ☐ Not sure/Don't know

2c) What might stop you from seeking help from this (person/service)?

☐ The cost of seeing the person

☐ Concern that the person might feel negatively about you ☐ Too embarrassed/shy

☐ Concern that what the person might say is wrong ☐Thinking that nothing can help

☐ Concern about what other people might think of you seeing the person

☐ The person/service is too far to travel to ☐ It is too hard to get an appointment

☐ Concern about the side effects of treatment

☐ Not liking the type of treatment that is likely to be offered

☐ Having to wait for an appointment ☐ Other (Specify)

☐ Don't know

There are a number of different people who could possibly help John with his problem. Please rate whether the following would be *helpful*, *harmful* or *neither* to John's problem.

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. A GP or family doctor	☐	☐	☐	☐	☐
2. A teacher	☐	☐	☐	☐	☐
3. A counsellor	☐	☐	☐	☐	☐
4. A telephone counseling service	☐	☐	☐	☐	☐

5. A psychologist	☐	☐	☐	☐	☐
6. A psychiatrist	☐	☐	☐	☐	☐
7. Other mental health professionals (social worker, mental health nurse)	☐	☐	☐	☐	☐
8. A close family member	☐	☐	☐	☐	☐
9. A close friend	☐	☐	☐	☐	☐
10. Dealing with his problems on his own	☐	☐	☐	☐	☐

Do you think the following medicines are likely to be *helpful*, *harmful* or *neither* for John's problem?

	Helpful	*Harmful*	*Neither*	*Depends*	*Don't know*
1. Vitamins	☐	☐	☐	☐	☐
2. St John's wort	☐	☐	☐	☐	☐
3. Antidepressants	☐	☐	☐	☐	☐
4. Tranquillizers	☐	☐	☐	☐	☐
5. Antipsychotics	☐	☐	☐	☐	☐
6. Sleeping pills	☐	☐	☐	☐	☐

The next few questions contain statements about John's problem. Please indicate how strongly you personally agree or disagree with each statement.

How strongly do you agree or disagree with following statements?

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
1. People with a problem like John's could snap out of it if they wanted.	0	1	2	3	4
2 A problem like John's is a sign of personal weakness	0	1	2	3	4
3. John's problem is not a real medical illness	0	1	2	3	4
4. People with a problem like John's are dangerous	0	1	2	3	4
5. It is best to avoid people with a problem like John's So that you don't become	0	1	2	3	4

depressed yourself					
6. People with a problem like John's depression are unpredictable	0	1	2	3	4
7. If I had a problem like John's I would not tell anyone	0	1	2	3	4
8. I would not employ someone if I knew they had a problem like John's	0	1	2	3	4
9. I would not vote for a politician if I knew they had suffered a problem like John's	0	1	2	3	4
10. Most people believe that people with a problem like John's could snap out of it if they wanted	0	1	2	3	4
11. Most people believe that a problem like John's is a sign of personal weakness	0	1	2	3	4
12. Most people believe that John's problem is not a real medical illness	0	1	2	3	4
13. Most people believe that people with a problem like John's are dangerous	0	1	2	3	4
14. Most people believe that it is best to avoid people with a problem like John's so that you don't develop this problem	0	1	2	3	4
15. Most people believe that	0	1	2	3	4

people with a problem like John's are unpredictable					
16. If they had a problem like john's (Mary's) most people would not tell anyone.	0	1	2	3	4
17. Most people would not employ someone they knew had suffered a problem like John's	0	1	2	3	4
18. Most people would not vote for a politician they knew had suffered a problem like John's	0	1	2	3	4

The following questions ask how you would feel about spending time with John. Would you be happy ….

	Yes, definitely	*Yes, probably*	*Probably not*	*Definitely not*	*Don't know*
To go out with John on the weekend?	☐	☐	☐	☐	☐
To work on a project with John?	☐	☐	☐	☐	☐
To invite John around to your house?	☐	☐	☐	☐	☐
To go to John's house?	☐	☐	☐	☐	☐
Would you be happy to develop a close friendship with John?	☐	☐	☐	☐	☐

How likely is John's situation caused by …. ?

	Very likely	*Somewhat likely*	*Not very likely*	*Not at all likely*
His own bad character	☐	☐	☐	☐
A brain disease or disorder	☐	☐	☐	☐
The way he was raised	☐	☐	☐	☐
Stress	☐	☐	☐	☐
A genetic or inherited problem	☐	☐	☐	☐
God's will	☐	☐	☐	☐

Bad luck	☐	☐	☐	☐
The normal ups-and-downs of life	☐	☐	☐	☐
A mental illness	☐	☐	☐	☐
A physical illness	☐	☐	☐	☐

Has anyone in your family or close circle of friends ever had a problem similar to John's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- have they received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

- have you ever had a problem similar to John's?

☐ Yes ☐ No ☐ Don't know

→ If YES:
- was this within the past 12 months?

☐ Yes ☐ No ☐ Don't know

- have you received any professional help or treatment for these problems?

☐ Yes ☐ No ☐ Don't know

→ If YES: Was this helpful?

☐ Yes ☐ No ☐ Don't know

1. Gender: □ male □ female

2. Age (in years): _____

3. Religion: □ Christian: __ Catholic
__ Protestant

__ Other: Please specify _____

□ Judaism

□ Buddhist

□ Muslim □ Hindu

□ Other: Please specify _____ □ None

4. Marital status: □ Single □ Married / Living with a partner

□ Divorced □ Widowed

5. Level of education: □ Primary School □ Secondary School

□ College/University □ Postgraduate studies (Masters)

□ Postgraduate studies (PhD) □ I did not go to school

□ Other (please specify)_____

6. How would you describe your ethnic origin?

WHITE: □ English □ Scottish □ Welsh □ Irish □ British □ Other (please specify: _____)

MIXED: □ White and Black Caribbean □ White and Black African □ White and Asian □ Other Mixed Background □ All Mixed groups

ASIAN or ASIAN BRITISH: □ Indian □ Pakistani □ Bangladeshi □ Other Asian background □ All Asian groups

BLACK or BLACK BRITISH: □ Caribbean □ African □ Other Black background □ All Black groups

CHINESE or Other Ethnic Group: □ Chinese □ Other ethnic group □ All Chinese or Other groups

Middle Eastern (please specify: _____)

Thank you very much for your time !

Appendix XV: Questionnaires for Adolescents (Bulgarian Translation)

Roehampton University London

Въпросници за непълнолетните участници

Скала за измерване на тревожността на Спенс

Моля, поставете кръгче около цифрата, която показва колко често ви се случват описаните ситуации:

	никога	понякога	често	винаги
1. Тревожа се за различни неща.	0	1	2	3

Страхувам се от тъмното.	0	1	2	3
Когато има проблем, изпитвам странно усещане в корема.	0	1	2	3
Изплашен съм.	0	1	2	3
5. Страхувам се да стоя сам вкъщи.	0	1	2	3
6. Страхувам се когато ми предстои изпит/тест.	0	1	2	3
7. Страхувам се да използвам обществени тоалетни.	0	1	2	3
8. Страхувам се да бъда далеч от родителите си.	0	1	2	3
9. Страхувам се, че ще изглеждам глупаво в очите на околните.	0	1	2	3
10. Страхувам се, че ще получа слаби оценки в училище.	0	1	2	3
11. Страхувам се, че нещо лошо ще се случи с някой от семейството ми.	0	1	2	3
12. Внезапно усещам, че не мога да си поема въздух, без да има причина за това.	0	1	2	3
13. Проверявам многократно, че съм свършил определени неща (заключване на вратата, изключване на ел.уреди)	0	1	2	3
14. Страхувам се когато трябва да спя сам.	0	1	2	3
15. Имам проблем с ходенето на училище, защото съм нервен и се страхувам.	0	1	2	3
16. Страхувам се от кучета.	0	1	2	3
17. Не мога да се отърва от лоши или глупави мисли.	0	1	2	3
18. Когато имам проблем, сърцето ми бие много бързо.	0	1	2	3
19. Внезапно започвам да треперя без да има видима причина за това.	0	1	2	3
20. Страхувам се, че ще ми се случи нещо лошо.	0	1	2	3
21. Страхувам се да посещавам лекар или зъболекар.	0	1	2	3
22. Когато имам проблем, се чувствам безсилен.	0	1	2	3
23. Страхувам се от високи сгради или асансьори.	0	1	2	3
24. Повтарям си мислено определени числа или думи, за да не ми се случат лоши неща.	0	1	2	3
25. Страхувам се когато трябва да пътувам с автомобил, автобус или влак.	0	1	2	3
26. Страхувам се от това, което околните биха си помислили за мен.	0	1	2	3
27. Страхувам се от оживени места (супермаркети, кина, автобуси, пазари).	0	1	2	3
28. Внезапно ме обзема страх без видима причина.	0	1	2	3

29. Страхувам се от насекоми.	0	1	2	3
30. Внезапно ми прилошава и припадам без видима причина.	0	1	2	3
31. Страхувам се когато трябва да говоря пред целия клас.	0	1	2	3
32. Сърцето ми започва внезапно да бие бързо без видима причина.	0	1	2	3
33. Тревожа се, че ме обзема страх, когато няма от какво да се страхувам.	0	1	2	3
34. Страхувам се от тесни, затворени пространства (тунели, асансьори).	0	1	2	3
35. Правя определени неща прекалено често (миене на ръце, чистене, поставяне на вещите в определен ред)	0	1	2	3
36. В съзнанието си имам глупави и лоши мисли, които ме плашат.	0	1	2	3
37. Трябва да правя някои неща в точно определен ред, за да попреча на лошото да се случи.	0	1	2	3
38. Страхувам се когато трябва да пренощувам на чуждо място.	0	1	2	3
39. Чувствам се доволен от живота си.	0	1	2	3
40. Обичам да се събуждам сутрин.	0	1	2	3

Себеконструктивна скала на Сингелис

Моля, поставете кръгче около цифрата, която показва доколко съгласен или несъгласен сте със следните изречения:

Ако някои от тях не се отнасят за вас, тъй като част от въпросите са съобразени с участниците ни в различна възраст, просто преминете към следващият въпрос.

	Напълно Съгласен	Съгласен	По-скоро съгласен	Нито съгласен, нито несъгла-сн	По-скоро несъглас ен	Не съ-гл ас ен	Напълно несъгласен
Изпитвам уважение към висшестоящ ите фигури, с които	7	6	5	4	3	2	1

общувам.							
Важно е за мен да поддържам хармония в групата, в която се движа.	7	6	5	4	3	2	1
Щастието ми зависи от щастието на тези около мен.	7	6	5	4	3	2	1
Бих предложил мястото си в автобуса на своя преподавател.	7	6	5	4	3	2	1
Уважавам хората хората, които се държат скромно.	7	6	5	4	3	2	1
Бих пренебрегнал собствениятси интерес за благото на групата, в която се движа.	7	6	5	4	3	2	1
Често имам чувството, че взаимоотношенията ми с останалитеса по-важни от моите собствени постижения.	7	6	5	4	3	2	1
Трябва да се съобразя със съвета на родителитеми когато вземам решения за образованието/кариерата ми.	7	6	5	4	3	2	1
Важно е за мен да	7	6	5	4	3	2	1

уважавам решенията, взети от групата, в която се движа.							
Бих останал с групата, ако тя се нуждае от мен, дори и ако това ме прави нещастен.	7	6	5	4	3	2	1
Ако братми/сестрами се провалят, се чувствам отговорен.	7	6	5	4	3	2	1
Избягвам спорове с членовете на групата, дори и когато не съм съгласен с решенията им.	7	6	5	4	3	2	1
Предпочитам да кажа „НЕ" директно, вместо да рискувам да остана неразбран.	7	6	5	4	3	2	1
Да се изкажа високо и ясно не е проблем за мен.	7	6	5	4	3	2	1
За мен е важно да имам богато въображение.	7	6	5	4	3	2	1
Чувствам се комфортно когато получавам похвали и награди.	7	6	5	4	3	2	1
Държа се по един и същ начин вкъщи и в	7	6	5	4	3	2	1

училище.							
Способността да се грижа за себе си е моята главна грижа.	7	6	5	4	3	2	1
Държа се по един и същ начин, независимо с кого общувам.	7	6	5	4	3	2	1
Удобно ми е да се обръщам към хора, които съм срещнал скоро, с малките им имена, дори когато са доста по-възрастни от мен.	7	6	5	4	3	2	1
Предпочитам да бъда директен и прям с хора, които току-що съм срещнал.	7	6	5	4	3	2	1
Харесва ми да бъда уникален и различен от останалите в много аспекти.	7	6	5	4	3	2	1
Моята индивидуална самоличност (независим от другите) е много важна за мен.	7	6	5	4	3	2	1
Ценя доброто здраве повече от всичко друго.	7	6	5	4	3	2	1

Въпросник на Гуудман за личните позиции

Моля, отбележете дали следните изречения за вас са „неверни", „донякъде верни" или „неверни". Отговорете на всички въпроси, дори и ако не сте съвсем сигурни, като се съобразите с това какви са били преживяванията ви през последните шест месеца.

	Невярно	**Донякъде вярно**	**Вярно**
Опитва се да бъда добър с околните. Вълнуват ме техните чувства.			
Неспокоен съм, не мога да стоя дълго на едно място.			
Често имам главоболие и стомашни болки.			
Споделям с останалите това, което имам (вещи, храна и др.)			
Ядосвам се бързо и не мога да се контролирам.			
Обикновено съм сам. Не обичам да съм сред хора.			
Обикновено правя това, което искат от мен.			
Често съм притеснен.			
Когато някой е разстроен, болен или нещастен, винаги помагам.			
Постоянно правя нещо с ръцете си или се въртя на едно място.			
Имам един добър приятел (или повече).			
Често влизам в конфликти. Мога да накарам хората да направят това, което искам.			
Често съм нещастен, подтиснат и тъжен.			
Моите връстници ме харесват.			
Бързо губя концентрация, трудно ми е да се съсредоточа.			
Нервен съм в нови ситуации, лесно губя увереност.			
Държа се добре с по-малките от мен.			
Често ме обвиняват в лъжа.			
Връстниците ми се заяждат с мен и ми създават проблеми.			
Често предлагам помощта си на околните (родители, учители, деца).			
Мисля преди да действам.			
Взимам чужди вещи от вкъщи, училище и др.			
Разбирам се по-добре с възрастните, отколкото с моите връстници.			

Имам много страхове, лесно се плаша.			
Концентрирам се добре, за да свърша определена работа.			

	Не	**Да-малки трудности**	**Да-съществени трудности**	**Да-големи трудности**
Като цяло, изпитвате ли трудности в следните области: Емоции, концентрация, поведение, разбирателство с околните?				

Ако сте отговорили с „Да” на този въпрос, моля отговорете на следните въпроси:

Откога имате тези трудности?

□ По-малко от месец □ 1-5 месеца

□ 6-12 месеца □ Повече от година

Тези трудности стресират ли ви?

□ Не □ Донякъде

□ Доста □ Много

Тези трудности пречат ли на вашето общуване в следните области?

- Семейни отношения □ Не □ Донякъде □ Доста □ Много
- Приятелства □ Не □ Донякъде □ Доста □ Много
- Учебен процес □ Не □ Донякъде □ Доста □ Много
- Развлечения □ Не □ Донякъде □ Доста □ Много

Тези трудности усещат ли се от тези около вас? (семейство, учители, приятели)?

□ Не □ Донякъде □ Доста □ Много

Скала за социалната подкрепа

Доколко усещате подкрепата на близките хора около вас?

Изберете числото, което най-добре съвпада с вашето мнение:

1=Не 2= Донякъде 3=Доста 4= Много

	Не	Донякъде	Доста	Много
Развеселят ви, когато се чувствате тъжни.	1	2	3	4
Успокояват ви когато някой е казал лоши неща за вас.	1	2	3	4
Ако ви се случи нещо хубаво, те се радват заедно с вас.	1	2	3	4
Когато не знаете как да постъпите, те ви помагат.	1	2	3	4
Винаги ви слушат внимателно, когато споделяте.	1	2	3	4
Ако не се справите добре с нещо, все пак ви подкрепят.	1	2	3	4
Веднага забелязват, че сте тъжни и имате нужда от подкрепа.	1	2	3	4
Слушат без да ви прекъсват, когато говорите за своите тревоги и проблеми.	1	2	3	4
Внимателно ви помагат, дори и когато допускате грешки.	1	2	3	4
Поздравяват ви сърдечно за вашите успехи.	1	2	3	4
Помагат ви с желание когато не можете да се справите сами.	1	2	3	4
Знаят за вашите чувства.	1	2	3	4
Винаги вярват във вас.	1	2	3	4
Ако знаят, че имате проблем, ще ви посъветват как да го разрешите.	1	2	3	4
Разбират напълно вашите предимства и недостатъци.	1	2	3	4
Отнасят се към вас с обич.	1	2	3	4

Скала за измерване на депресията на Центъра за епидемиологични изследвания

През изминалата седмица:	**Не**	**Донякъде**	**Доста**	**Много**

	3	2	1	0
Тревожеха ме неща, които не са ме тревожили досега.				
Нямах добър апетит.				
Не се чувствах щастлив, дори и когато близките ми се опитваха да ме окуражат.				
Чувствах, че не съм по-лош от връстниците си.				
Не можех да се съсредоточа върху нещата, които вършех.				
Чувствах се нещастен и подтиснат.				
Чувствах се твърде уморен, за да правя каквото и да е.				
Усещах, че ще ми се случи нещо хубаво.				
Нещата, които обикновено правя добре, не ми се получаваха.				
Чувствах се уплашен.				
Нямах здрав сън.				
Бях щастлив.				
Бях по-тих от обикновено.				
Чувствах се самотен и без приятели.				
Чувствах, че връстниците ми не бяха приятелски настроени и не искаха да общуват с мен.				
Забавлявах се добре.				
Плачеше ми се.				
Бях тъжен.				
Чувствах, че хората не ме харесват.				
Трудно ми беше да започна каквото и да е.				

Иван е на 15 години. През последните няколко седмици той се чувства подтиснат и тъжен. Чувства се изморен през цялото време и има проблеми със съня. Иван няма апетит и е отслабнал. Не може да се съсредоточи върху учебната работа и получава слаби оценки. Той отлага вземането на решения и дори ежедневните задължения за него са непосилни. Неговите родители и приятели са загрижени за състоянието му.

1. Какво му има на Иван според вас?

_____

---

2. Ако имате проблем като този на Иван, бихте ли потърсили помощ?

☐ Да ☐ Не ☐ Не знам

2а) Ако сте отговорили с „Да", към кого бихте се обърнали?

☐ Към двамата родители ☐ Към майката

☐ Към бащата

☐ Към друг близък човек (пояснете кой): _____

☐ Към професионалист (пояснете кой): _____

☐ Не знам

2b) Колко сте сигурен във възможността да поискате помощ от този професионалист?

Бихте ли казали…?

☐ Много сигурен ☐ Доста сигурен ☐ Не съвсем сигурен

☐ Несигурен ☐ Не знам

2c) Какво би ви попречило да потърсите помощ от този професионалист?

☐ Цената на подобен вид помощ

☐ Опасението, че човекът може да реагира негативно спрямо вас

☐ Твърде съм притеснен, срамувам се да потърся помощ

☐ Опасението, че хората ще се произнесат лошо за подобно нещо

☐ Мисленето, че нищо не може да помогне

☐ Страхът от това, което ще си помислят хората за такова посещение

☐ Човекът/ професионалистът е твърде далеч и е неудобно да се пътува дотам

☐ Твърде трудно е да се уреди преглед/консултация

☐ Страхът от страничните ефекти на лечението

☐ Не ми допада лечението, което вероятно ще ми предложат

☐ Трябва да се чака за преглед/консултация

☐ Друго (Пояснете:.....)

☐ Не знам

Има хора, които биха могли да помогнат на Иван да разреши проблема си. Как преценявате, следните хора могат ли да помогнат на Иван или по-скоро биха му навредили?

	Ще помогне	Ще навреди	Нито едно от другото	Зависи	Не знам
1. Семеен лекар	□	□	□	□	□
2. Учител	□	□	□	□	□
3. Психотерапевт	□	□	□	□	□
4. Телефонна консултация със специалист	□	□	□	□	□
5. Психолог	□	□	□	□	□
6. Психиатър	□	□	□	□	□
7. Социален работник	□	□	□	□	□
8. Близък човек от семейството	□	□	□	□	□
9. Близък приятел	□	□	□	□	□
10. Справяне с проблемите самостоятелно	□	□	□	□	□

Мислите ли, че следните медикаменти биха помогнали или навредили на Иван?

	Ще помо	Ще навред	Нито едно ни	Зависи	Не знам

	гне	и	тодругото		
1. Витамини	☐	☐	☐	☐	☐
2. Билколечение	☐	☐	☐	☐	☐
3. Антидепресанти	☐	☐	☐	☐	☐
4. Успокоителни	☐	☐	☐	☐	☐
5. Психотропни препарати (невролептици)	☐	☐	☐	☐	☐
6. Сънотворни	☐	☐	☐	☐	☐

Мислите ли, че следните неща биха помогнали или навредили на Иван?

	Щепомогне	Щенавреди	Нитоедноитодругото	Зависи	Незнам
1. Поддържане на добра физическа активност	□	□	□	□	□
2. Релаксация	□	□	□	□	□
3. Медитиране	□	□	□	□	□
4. Професионални масажи	□	□	□	□	□
5. Акупунктура	□	□	□	□	□
6. Ранно ставане и излети сред природата	□	□	□	□	□
7. Помощ от психолог	□	□	□	□	□
8. Поведенческа терапия	□	□	□	□	□
9. Търсене на информация за проблемите по интернет	□	□	□	□	□
10. Четене на книга за проблемите	□	□	□	□	□
11. Присъединяване към група от хора с подобни проблеми	□	□	□	□	□
12. Търсене на помощ от специалисти (социални работници)	□	□	□	□	□
13. Лекуване в болнична обстановка	□	□	□	□	□

14. Пиене на алкохол	□	□	□	□	□
15. Пушене на цигари	□	□	□	□	□
16. Употреба на марихуана	□	□	□	□	□
17. Въздържание от алкохолна консумация	□	□	□	□	□
18. Спиране на цигарите	□	□	□	□	□
19. Спиране на употребата на марихуана	□	□	□	□	□

Следващите въпроси се отнасят до нещата, които Иван би могъл да направи, за да намали риска от подобни проблеми. Ако някой на възрастта на Иван извърша следните действия, те ще му помогнат ли или ще му навредят?

	Щепомогне	Щенавреди	Нитоединотонитодругото	Зависи	Незнам
1. Поддържане на физическа активност	☐	☐	☐	☐	☐
2. Избягване на проблемни ситуации stressful	☐	☐	☐	☐	☐
3. Поддържане на близки контакти с приятели	☐	☐	☐	☐	☐
4. Поддържане на близки контакти с другите членове на семейството	☐	☐	☐	☐	☐
5. Избягване на храни с високо съдържание на захар	☐	☐	☐	☐	☐
6. Отказване от цигарите	☐	☐	☐	☐	☐
7. Отказване от алкохола	☐	☐	☐	☐	☐
8. Отделяне на време за почивка activities	☐	☐	☐	☐	☐
9. Религиозна вяра	☐	☐	☐	☐	☐

Следващите въпроси съдържат твърдения за състоянието на Иван. Моля, отбележете цифрата, която отбелязва доколко се съгласявате с всяко едно от тях:

	Напълно несъгласен	Несъгласен	Нито съгласен нито несъгл	Съгласен	Напълно съгласен	Незнм

					асен		
	Иван може да се оправи много бързо, стига да иска.	☐	☐	☐	☐	☐	☐
	Проблемът на Иван е знак за лична слабост.	☐	☐	☐	☐	☐	☐
	Проблемът на Иван не е истинска болест.	☐	☐	☐	☐	☐	☐
	Иван е опасен за околните.	☐	☐	☐	☐	☐	☐
	Най-добре е да избягваме хора като Иван, за да не прихванем техните проблеми.	☐	☐	☐	☐	☐	☐
	Проблемът на Иван го прави непредсказуем.	☐	☐	☐	☐	☐	☐
	Не бих казал на никого, ако имам проблем като този на Иван.	☐	☐	☐	☐	☐	☐

Досега отбелязахте какво мислите вие за този проблем. Сега изберете как според вас мислят повечето хора за състоянието на Иван:

	Напълно несъгласен	Несъгласен	Нито съгласен нито несъгласен	Съгласен	Напълно съгласен	Не знам
Повечето хора вярват, че Иван може да се оправи бързо, стига да иска.	☐	☐	☐	☐	☐	☐
Повечето хора вярват, че проблемът на Иван е знак за лична слабост.	☐	☐	☐	☐	☐	☐
Повечето хора вярват, че проблемът на Иван не е истинска болест.	☐	☐	☐	☐	☐	☐
Повечето хора вярват, е Иван е опасен за околните.	☐	☐	☐	☐	☐	☐
Повечето хора вярват, че хора като Иван трябва да се избягват, за да не прихванат техните проблеми.	☐	☐	☐	☐	☐	☐
Повечето хора вярват, че проблемът на Иван го прави	☐	☐	☐	☐	☐	☐

непредска зуем.						
Повечето хора не биха казали на никого, ако имат проблем като този на Иван.	☐	☐	☐	☐	☐	☐

Следващите въпроси за за това как вие бихте се чувствали в компанията на Иван.

Бихте ли ….

	Да, естествено	*Да, може би*	*Може би не*	*Определено не*	*Не знам*
Излезли с Иван през уикенда?	☐	☐	☐	☐	☐
Работили заедно с него?	☐	☐	☐	☐	☐
Поканили Иван у вас?	☐	☐	☐	☐	☐
Отишли на гости у Иван?	☐	☐	☐	☐	☐
Поддържали близки приятелски отношения с Иван?	☐	☐	☐	☐	☐

Колко вероятно е проблемът на Иван да е причинен от …. ?

	Много вероятно	*Донякъде вероятно*	*Не много вероятно*	*Много невероятно*
Неговият лош характер	□	□	□	□
Заболяване на мозъка	□	□	□	□
Начинът, по който е бил възпитан	□	□	□	□
Стрес	□	□	□	□

Генетичен (наследствен) проблем	□	□	□	□
Божия воля	□	□	□	□
Лош късмет	□	□	□	□
Нормалните приливи и отливи в живота	□	□	□	□
Психично заболяване	□	□	□	□
Физическо заболяване	□	□	□	□

Имал ли е някой в семейството ви или близък кръг приятели, проблем като този на Иван?

☐ Да ☐ Не ☐ Не знам

→ Ако Да:

- получил ли е този човек професионална помощ?

☐ Да ☐ Не ☐ Не знам

- Вие имали ли сте проблем като този на Иван?

☐ Да ☐ Не ☐ Не знам

→ Ако Да:

- това в рамките на изминалата година ли се случи?

☐ Да ☐ Не ☐ Не знам

- Получили ли сте професионална помощ за този проблем?

☐ Да ☐ Не ☐ Не знам

→ Ако Да, помогна ли ви наистина?

☐ Да ☐ Не ☐ Не знам

Вашите данни:

1. Пол: □ мъжки □ женски

2. Възраст: _____

Религия:

□ Християнство

□ Ислям

□ Друга _____

□ Без религия

4. Вашият етнически произход?

□ Български □ Турски □ Ромски □ Друг.....

Благодарим ви сърдечно за търпението и помощта!

Appendix XVI: Questionnaires for Adults (Bulgarian translation)

Roehampton University London

Въпросници за пълнолетните участници

Скала за измерване на тревожността на Спенс –Есау

Моля, поставете кръгче около цифрата, която показва колко често ви се случват описаните ситуации:

	никога	понякога	често	винаги
1. Страхувам се, че не се държа по подходящ начин и се излагам пред околните.	0	1	2	3
2. Страхувам се от светкавици, гръмотевици и бури.	0	1	2	3
3. Понякога усещам, че не мога да дишам и чувствам, че ще припадна, без да има очевидна причина за това.	0	1	2	3
4. Страхувам се от височини (скали, балкони, високи сгради).	0	1	2	3

5. Трябва да проверявам по няколко пъти, че съм свършил определени неща (изключване на ел.уреди, заключване на вратата и др.).	0	1	2	3
6. Страхувам се да произнасям речи и да говоря публично	0	1	2	3
7. Внезапно ме обзема страх и започвам да треперя, без да има очевидна причина за това.	0	1	2	3
8. Изпитвам желание да върша неуместни действия и трудно мога да се контролирам в такива моменти.	0	1	2	3
9. Внезапно ме обзема усещане за опасност и мисълта, че ще се случи нещо ужасно	0	1	2	3
10. Правя някои неща много бавно, защото искам да ги направя по точно определен начин.	0	1	2	3
11. Тревожа се за най-различни неща.	0	1	2	3
12. Чувствам се тревожен в ситуациите, в които съм център на внимание.	0	1	2	3
13. Страхувам се от летене със самолет.	0	1	2	3
14. Повтарям си мислено определени числа или думи, за да не ми се случат лоши неща.	0	1	2	3
15. Страхувам се да започна разговор с непознат човек.	0	1	2	3
16. Трудно ми е да спра да се тревожа.	0	1	2	3
17. Страхувам се от затворени пространства (пещери, тунели, асансьори)	0	1	2	3
18. Внезапно ме обзема страх от загуба на контрол.	0	1	2	3
19. Правя определени неща многократно и непрекъснато (миене на ръце, чистене, подреждане на вещи в определен ред).	0	1	2	3
20. Чувствам се напрегнат, раздразнителен и изнервен.	0	1	2	3
21. Страхувам се когато видя кръв	0	1	2	3
22. Сърцето ми започва да бие учестено без видима причина.	0	1	2	3
23. Страхувам се, че ще ми стане зле, когато излизам навън.	0	1	2	3
24. Разстройват ме лоши и неприятни мисли, които се явяват в съзнанието ми без моето желание.	0	1	2	3
25. Страхувам се, че изглеждам глупаво в очите на околните.	0	1	2	3
26. Страхувам се когато трябва да ми поставят инжекция при лекаря или зъболекаря.	0	1	2	3
27. Трябва да направя някои неща по точно определен начин, за да попреча на лошото да се случи.	0	1	2	3
28. Заспивам трудно и сънят ми е неспокоен.	0	1	2	3
29. Нервен съм когато ме представят пред непознати хора.	0	1	2	3
30. Страхувам се от насекоми, птици, влечуги или мишки.	0	1	2	3
31. В съзнанието ми повторяемо се появяват страшни или срамни образи и мисли.	0	1	2	3

32. Страхувам се от оживени места (супермаркети, автобуси, пазари).	0	1	2	3
33. Не обичам да използвам неща, употребявани от други хора (обществени телефони, обществени тоалетни, седалки в градският транспорт).	0	1	2	3
39. Доволен съм от живота си.	0	1	2	3
40. Обичам да се събуждам сутрин.	0	1	2	3

Себеконструктивна скала на Сингелис

Моля, поставете кръгче около цифрата, която показва доколко съгласен/а или несъгласен/а сте със следните изречения:

Ако някои от тях не се отнасят за вас, тъй като част от въпросите са съобразени с участниците ни в различна възраст, просто преминете към следващият въпрос.

	Напълно Съгласен	Съгласен	По-скоро съгласен	Нито съгласен, нито несъгла-сен	По-скоро несъглас ен	Несъ-гласен	Напълно несъглас ен
Изпитвам уважение към висшестоящите фигури, с които общувам.	7	6	5	4	3	2	1
Важно е за мен да поддържам хармония в групата, в която се движа.	7	6	5	4	3	2	1
Щастието ми зависи от щастието на тези около мен.	7	6	5	4	3	2	1
Бих предложил мястото си в автобуса на своя преподавател.	7	6	5	4	3	2	1
Уважавам хората, които се държат скромно.	7	6	5	4	3	2	1
Бих пренебрегнал собственият си интерес за благото на групата, в която се движа.	7	6	5	4	3	2	1
Често имам чувството, че взаимоотношенията ми с останалите са по-	7	6	5	4	3	2	1

важни от моите собствени постижения.							
Трябва да се съобразя със съвета на родителите ми когато вземам решения за образованието/кариерата ми.	7	6	5	4	3	2	1
Важно е за мен да уважавам решенията, взети от групата, в която се движа.	7	6	5	4	3	2	1
Бих останал с групата, ако тя се нуждае от мен, дори и ако това ме прави нещастен.	7	6	5	4	3	2	1
Ако брат ми/сестра ми се провалят, се чувствам отговорен.	7	6	5	4	3	2	1
Избягвам спорове с членовете на групата, дори и когато не съм съгласен с решенията им.	7	6	5	4	3	2	1
Предпочитам да кажа „НЕ” директно, вместо да рискувам да остана неразбран.	7	6	5	4	3	2	1
Да се изкажа високо и ясно не е проблем за мен.	7	6	5	4	3	2	1
За мен е важно да имам богато въображение.	7	6	5	4	3	2	1
Чувствам се комфортно когато получавам похвали и награди.	7	6	5	4	3	2	1
Държа се по един и същ начин вкъщи и в училище.	7	6	5	4	3	2	1
Способността да се грижа за себе си е моята главна грижа.	7	6	5	4	3	2	1
Държа се по един и същ начин, независимо с кого общувам.	7	6	5	4	3	2	1
Удобно ми е да се обръщам към хора, които съм срещнал скоро, с малките им имена, дори когато са доста по-възрастни от мен.	7	6	5	4	3	2	1
Предпочитам да бъда директен и прям с хора, които току-що съм срещнал.	7	6	5	4	3	2	1
Харесва ми да бъда уникален и различен от останалите в много аспекти.	7	6	5	4	3	2	1
Моята индивидуална самоличност (независим/а от другите) е много важна за мен.	7	6	5	4	3	2	1
Ценя доброто здраве повече от всичко друго.	7	6	5	4	3	2	1

Скала на депресията, тревожността и стреса на Ловибонд § Ловибонд (DASS- 21)

Моля, изберете цифра от 0 до 3, която показва колко често са ви се случвали изброените неща през ИЗМИНАЛАТА СЕДМИЦА.

Цифрите имат следното обозначение:

0 Нито веднъж

1 Един или два пъти

2 През значителна част от времето

3 Почти през цялото време

	Трудно ми беше да се успокоя	0	1	2	3
	Усещах сухота в гърлото	0	1	2	3
	Не бях в състояние да изпитам положително чувство	0	1	2	3
	Имах затруднения с дишането (дишах учестено или не ми стигаше въздуха, без да съм се натоварвал/а физически)	0	1	2	3
	Трудно ми беше да поема инициативата да свърша нещо	0	1	2	3
	Реагирах пресилено в ситуациите	0	1	2	3
	Трепереха ми ръцете	0	1	2	3
	Усещах, че използвам много нервна енергия	0	1	2	3
	Страхувах се от ситуации, в които можех да изпитам паника и да изглеждам глупаво пред околните	0	1	2	3
	Усещах, че не ме очаква нищо хубаво	0	1	2	3
	Чувствах се превъзбуден/а и неспокоен/а	0	1	2	3
	Трудно ми беше да се отпусна	0	1	2	3
	Чувствах се депресиран/а и тъжен/а	0	1	2	3
	Проявявах крайна нетърпимост към всичко, което ми пречеше да свърша запланованото	0	1	2	3
	Чувствах се на ръба на паниката	0	1	2	3
	Не можех да изпитам ентусиазъм за каквото и да е	0	1	2	3
	Чувствах, че не съм ценен/а като личност	0	1	2	3
	Усещах, че съм много докачлив/а	0	1	2	3
	Усещах как сърцето ми бие учестено или неритмично, без да съм се натоварвал/а физически	0	1	2	3

Чувствах се уплашен без видима причина	0	1	2	3
Чувствах, че животът няма смисъл	0	1	2	3

Берлинска скала за социалната подкрепа

Отговорете с „ДА” или „НЕ” на следните въпроси:

	Да	Не
1. Има хора, които наистина ме харесват.		
2. Винаги, когато не се чувствам добре, другите ме подкрепят.		
3. Когато съм тъжен/а, има хора, които ме развеселяват.		
4. Винаги има някой, който ме успокоява, когато имам нужда от това.		
5. Познавам хора, на които мога да разчитам винаги.		
6. Винаги получавам подкрепа, когато съм разтревожен.		
7. Има хора, които ми предлагат помощта си, ако се нуждая от нея.		
8. Когато нещата са трудно поносими за мен, другите ми предлагат подкрепата си.		

Иван е на 30 години. Той се чувства необичайно тъжен и нещастен през последните няколко седмици. Независимо от това, че е много изморен, той има проблеми със съня почти всяка вечер. Иван няма апетит и е отслабнал. Не може да се фокусира в работата си и отлага вземането на решения. Дори и ежедневните задължения са непосилни за него. Шефът на Иван е забелязал това, както и неговата занижена продуктивност.

1.Какво му има на Иван, според вас?

_____

_____

2 . Ако имате проблем като този на Иван, бихте ли потърсили професионална помощ?

☐ Да ☐ Не ☐ Не знам

2a) Ако сте отговорили с „Да”, от кого? _____

2b) Колко сте сигурен/а във възможността да поискате помощ от този професионалист? Бихте ли казали…?

☐ Много сигурен ☐ Доста сигурен ☐ Не съвсем сигурен

☐ Несигурен ☐ Не знам

2c) Какво би ви попречило да потърсите помощ от този професионалист?

☐ Цената на подобен вид помощ

☐ Опасението, че човекът може да реагира негативно спрямо вас

☐ Твърде съм притеснен, срамувам се да потърся помощ

☐ Опасението, че хората ще се произнесат лошо за подобно нещо

☐ Мисленето, че нищо не може да помогне

☐ Страхът от това, което ще си помислят хората за такова посещение

☐ Човекът/ професионалистът е твърде далеч и е неудобно да се пътува дотам

☐ Твърде трудно е да се уреди преглед/консултация

☐ Страхът от страничните ефекти на лечението

☐ Не ми допада лечението, което вероятно ще ми предложат

☐ Трябва да се чака за преглед/консултация

☐ Друго (Пояснете:.....)

☐ Не знам

Има хора, които биха могли да помогнат на Иван да разреши проблема си. Как преценявате, следните хора могат ли да помогнат на Иван или по-скоро биха му навредили?

	Ще помогне	Ще навреди	Нито едно от другото	Зависи	Не знам
1. Семеен лекар	☐	☐	☐	☐	☐
2. Учител	☐	☐	☐	☐	☐
3. Психотерапевт	☐	☐	☐	☐	☐
4. Телефонна консултация със специалист	☐	☐	☐	☐	☐
5. Психолог	☐	☐	☐	☐	☐
6. Психиатър	☐	☐	☐	☐	☐
7. Социален работник	☐	☐	☐	☐	☐
8. Близък човек от семейството	☐	☐	☐	☐	☐
9. Близък приятел	☐	☐	☐	☐	☐
10. Справяне с проблемите самостоятелно	☐	☐	☐	☐	☐

Мислите ли, че следните медикаменти биха помогнали или навредили на Иван?

	Ще помогн	Ще навре	Нито едно от другото	Зависи	Не знам

	е	д и	уг от о		
1. Витамини	☐	☐	☐	☐	☐
2. Билколечение	☐	☐	☐	☐	☐
3. Антидепресанти	☐	☐	☐	☐	☐
4. Успокоителни	☐	☐	☐	☐	☐
5. Психотропни препарати (невролептици)	☐	☐	☐	☐	☐
6. Сънотворни	☐	☐	☐	☐	☐

Следващите въпроси съдържат твърдения за проблема на Иван. Моля, посочете доколко се съгласявате с всеки един от тях:

	Напълно несъгласен	Несъгласен	Нито съгласен, нито несъгласен	Съгласен	Напълно съгласен
1. Хора с проблем като този на Иван могат да се оправят бързо, стига да искат.	0	1	2	3	4
2 Проблем като този на Иван е знак за лична слабост.	0	1	2	3	4
3. Проблемът на Иван всъщност не е истинска болест	0	1	2	3	4
4. Хора с проблем като този на Иван са опасни.	0	1	2	3	4

5. Най-добре е хора като Иван да бъдат избягвани, за да не се депресираме.	0	1	2	3	4
6. Хора с проблем като депресията на Иван са непредсказуеми.	0	1	2	3	4
7. Ако имах проблем като този на Иван, не бих казал на никого.	0	1	2	3	4
8. Не бих дал работа на човек с проблем като този на Иван.	0	1	2	3	4
9. Не бих гласувал за политик, ако знам, че е изживял проблем като този на Иван.	0	1	2	3	4
10. Повечето хора вярват, че хора като Иван могат лесно да се оправят, стига да искат.	0	1	2	3	4
11. Повечето хора вярват, че проблем като този на Иван е знак за лична слабост.	0	1	2	3	4
12. Повечето хора вярват, че проблем като този на	0	1	2	3	4

Иван всъщност не е истинска болест.					
13. Повечето хора вярват, че хора с проблем като този на Иван са опасни.	0	1	2	3	4
14. Повечето хора вярват, че е най-добре хора като Иван да бъдат избягвани, за да не се депресираме	0	1	2	3	4
15. Повечето хора вярват, че хора с проблем като този на Иван са непредсказуеми	0	1	2	3	4
16. Ако имат проблем като този на Иван, повечето хора не биха казали на никого	0	1	2	3	4
17. Повечето хора не биха дали работа на някого с проблем като този на Иван	0	1	2	3	4
18. Повечето хора не биха гласували за политик, ако знаят, че той е изживял проблем като този на Иван.	0	1	2	3	4

Следващите въпроси за за това как вие бихте се чувствали в компанията на Иван.

Бихте ли ….

	Да, естествено	*Да, може би*	*Може би не*	*Определено не*	*Не знам*
Излезли с Иван през уикенда?	☐	☐	☐	☐	☐
Работили заедно с него?	☐	☐	☐	☐	☐
Поканили Иван у вас?	☐	☐	☐	☐	☐
Отишли на гости у Иван?	☐	☐	☐	☐	☐
Поддържали близки приятелски отношения с Иван?	☐	☐	☐	☐	☐

Колко вероятно е проблемът на Иван да е причинен от …. ?

	Много вероятно	*Донякъде вероятно*	*Не много вероятно*	*Много невероятно*
Неговият лош характер	□	□	□	□
Заболяване на мозъка	□	□	□	□
Начинът, по който е бил възпитан	□	□	□	□
Стрес	□	□	□	□
Генетичен (наследствен)проблем	□	□	□	□
Божия воля	□	□	□	□
Лош късмет	□	□	□	□
Нормалните приливи и отливи в живота	□	□	□	□
Психично заболяване	□	□	□	□
Физическо заболяване	□	□	□	□

Имал ли е някой в семейството ви или близък кръг приятели, проблем като този на Иван?

☐ Да ☐ Не ☐ Не знам

→ Ако Да:

- получил ли е този човек професионална помощ?

☐ Да ☐ Не ☐ Не знам

- Вие имали ли сте проблем като този на Иван?

☐ Да ☐ Не ☐ Не знам

→ Ако Да:

- това в рамките на изминалата година ли се случи?

☐ Да ☐ Не ☐ Не знам

- Получили ли сте професионална помощ за този проблем?

☐ Да ☐ Не ☐ Не знам

→ Ако Да, помогна ли ви наистина?

☐ Да ☐ Не ☐ Не знам

Вашите данни:

1. Пол: ☐ мъжки ☐ женски

2. Възраст: _____

Религия:

☐ Християнство

☐ Ислям

□ Друга _____

□ Без религия

4. Семейно положение: □ Неженен/неомъжена □ Женен/омъжена/живущ на семейни начала □ Разведен/а □ Вдовец/вдовица

5. Образование: □ Основно образование □ Средно образование □ Колеж/ Университет □ Магистратура/ Докторантура □ Не съм ходил на училище

□ Друго_____

6. Вашият етнически произход?

□ Български □ Турски □ Ромски □ Друг.....

Благодарим ви сърдечно за търпението и помощта!

Appendix XVII A table of initial comments for Anna, 14

	Original transcript	Exploratory comments
	- Hi, Anna. I would like you to tell me how does anxiety make you feel? - I feel powerless when anxious. As if no-one and nothing can help me. My palms get sweaty, I feel hot and start blushing. I feel anxious before exams or when I	*Is there an underlying thinking that she cannot control her anxiety, nor can rely on anybody else to help her with it? Strong use of "NO" – nothing, no-one.* Physical description of anxiety, which quickly gives place to deeper, more conceptual thoughts.

	have to speak in front of the whole class. I do not like attention very much and prefer to sit quietly. Sometimes I have difficulties speaking because of my lisp and when I am anxious I speak even worse. Some of my schoolmates are understanding, but others can't help laughing at me from time to time. I do not pay attention to them. My school work is good and I want to become a vet. - Describe your anxiety in your own words for me. What are your fears? - Anxiety is like a dry patch in my mouth. I feel it there when my dad is driving very fast on the motorway, it makes me feel dizzy. I do not want to go to the opticians as I do not want to wear glasses and my mum is having a hard time trying to convince me to go, as I have problems with my eyesight. I am scared that people would notice so I	<u>Self –consciousness and shyness, introversion</u> Impact of anxiety Moves on to physical characteristics again, but this time they lead to school microclimate and social relationships. *Uses diminutive language constructs – "some people" do it, "Sometimes", so no big deal* – she puts herself above it by distancing from it. School work performance is her <u>comfort zone, where she feels she is good</u>. <u>She is immersing herself in dreams of the future – escapism?</u> Always focuses on the physical parts when asked to "describe". *Repeat use of "I do not want" metaphoric use*, family is introduced vaguely – both parents do something that makes her feel uncomfortable. <u>Low self-esteem, hiding</u> Before she starts

	wear a long fringe. I am also scared of drunk people – no-one in my family drinks alcohol, but once we had a drunk person trying to break into our house. Me and my older sister were alone, so we ran to our neighbours for help. I was scared that he would kill us - I am terrified of dying. My great grandfather died two years ago and I cried a lot – I hate funerals and cemeteries. They give me bad dreams and I can't sleep properly. .. - Which other things do you feel afraid of? - I am afraid that I will disappoint my parents. My parents want me to be a lawyer as four generations of my family have worked as lawyers. But I just do not find law interesting. So I am scared to talk to them about my choice of career as a good daughter will not disobey the family traditions. Sometimes I feel	sharing a traumatic experience, she distinguishes herself and people close to her from "bad drunks" Continuously detaches herself from traumatic moments *A lot of "I" and "me" in the expression of personal thoughts and experiences* Death and dying as primary fears are tied with personal experience Tackles pain and grief by expressing hate towards the "signs" indicating that it has happened. Does not elaborate on emotions, connected with the deceased relative – just the personal repercussions as a result. Guilt, family duty, fear of family resentment Family again is presented as a group of people, who make her do something she is not willing to. Uncertainty, inability to defend personal choices, doubts - do I

	like speaking, but the words just do not come out – my heart starts beating faster, my eyes become sore and I just say to myself "maybe another time". I do not want to see my mum crying - as she and my dad are very good parents to me and my sister. Even at hard times we had everything we could wish for – pets, nice clothes, lovely holidays. I dread the moment when she (the mother) will say to me: "You have failed us, we gave you everything and what you have done is unacceptable". You see, one of us, me or my sister will have to keep the tradition alive, but she did not perform well in school because of her learning difficulties, so it is entirely up to me. And I do not want to feel guilty. But I cannot be a bad daughter either. Once my mum caught me smoking a cigarette and I will never forget the look on her face – I promised her I	have the right to be "selfish" by insisting on my choice of career? Moral, traditions and obedience Procrastination plus more intense physical descriptions of emotion *"Do not come out", "do not want" – it is a feeling of hopelessness and lack of choice which ties linguistically with the very beginning of the transcript* She is justifying her obligation to be an obedient daughter – by "returning" the sacrifices, made by parents. Surprisingly unemotional when talking about childhood – focusing on material things as signs of happy times, not on emotional closeness. *"You see" –looking for assurance that ignoring oneself is the only way to be thought of as a good daughter.* Pressure, taking the responsibility instead

	would never do it again and I haven't. A cigarette is just a one-off, but a choice of career is for life, so I can not disappoint them. My biggest fear is losing their approval and love – this is something I will not be able to live with. One day when my parents are gone, I will probably have to support my sister and I need to be well-off financially – in this country vets are not paid very much, so it is not a wise choice of profession. - Are you afraid of anything else? - No, I just do not want them to find out about my fears...yet, as I am not ready to tell them. - Our conversation is confidential, Anna. Thank you for your help.		of her ill sister. More fear, promises and a poignant episode where a small disappointment was met with a level of disapproval she felt unable to deal with Identifies herself only as a part of the family – daughter and sister. Cannot imagine living outside the family cocoon. Safety and comfort zone again Tries to diminish her original choice of career (sour grapes) in order to convince herself it was not an appropriate one and achieve piece with herself Preoccupied with materialistic thoughts Fear of parental disappointment is woven into the transcript. *Lots of pauses in this part, hesitance - she did not know how to formulate the fear of being "caught out"* What she has just disclosed made her feel vulnerable so she needed lots or

		reassurance.

Appendix XVIII A Table of Emergent Themes for Anna, 14

Emergent themes	Original transcript	Exploratory comments
The powerless self Lack of self-esteem Social contacts/relationships problematic The self as performance Exploring the self as a process	- Hi, Anna. I would like you to tell me how does anxiety make you feel? - I feel powerless when anxious. As if no-one and nothing can help me. My palms get sweaty, I feel hot and start blushing. I feel anxious before exams or when I have to speak in front of the whole class. I do not like attention very much and prefer to sit quietly. Sometimes I have difficulties speaking because of my lisp and when I am anxious I speak even worse. Some of my schoolmates are understanding, but others can't help laughing at me from time to time. I do not pay attention to them. My school work is good and I want to become a vet. - Describe your anxiety in your own words for me. What are your fears? - Anxiety is like a dry patch in my mouth. I feel it there when my dad is	*Is there an underlying thinking that she cannot control her anxiety, nor can rely on anybody else to help her with it? Strong use of "NO" – nothing, no-one.* Physical description of anxiety, which quickly gives place to deeper, more conceptual thoughts. Self –consciousness and shyness, introversion Impact of anxiety Moves on to physical characteristics again, but this time they lead to school microclimate and social relationships. *Uses diminutive language constructs – "some people" do it, "Sometimes", so no big deal* – she puts herself above it by distancing from it. School work performance is her comfort zone, where she feels she is good. She is immersing

Coping as a process Academic self-perspective The self as an image Expression of self Self-criticism Schemas and organizing of information processing The mortal self Shock	driving very fast on the motorway, it makes me feel dizzy. I do not want to go to the opticians as I do not want to wear glasses and my mum is having a hard time trying to convince me to go, as I have problems with my eyesight. I am scared that people would notice so I wear a long fringe. I am also scared of drunk people – no-one in my family drinks alcohol, but once we had a drunk person trying to break into our house. Me and my older sister were alone, so we ran to our neighbours for help. I was scared that he would kill us - I am terrified of dying. My great grandfather died two years ago and I cried a lot – I hate funerals and cemeteries. They give me bad dreams and I can't sleep properly. .. - Which other things do you feel afraid of? - I am afraid that I will disappoint my parents. My parents want me to be a lawyer as four generations of my family have worked as lawyers. But I just do not find law interesting. So I am scared to talk to them about my choice of career as a good daughter will not disobey the family traditions. Sometimes I feel like speaking, but the words just do not come out – my heart starts beating faster, my eyes become sore and I just say to myself "maybe another time". I do not want to see my mum	herself in dreams of the future – escapism? Always focuses on the physical parts when asked to "describe". *Repeat use of "I do not want" metaphoric use,* family is introduced vaguely – both parents do something that makes her feel uncomfortable. Low self-esteem, hiding Before she starts sharing a traumatic experience, she distinguishes herself and people close to her from "bad drunks" Continuously detaches herself from traumatic moments *A lot of "I" and "me" in the expression of personal thoughts and experiences* Death and dying as primary fears are tied with personal experience Tackles pain and grief by expressing hate towards the "signs" indicating that it has happened. Does not elaborate on emotions, connected with the deceased relative – just the personal repercussions as a result. Guilt, family duty, fear of family resentment Family again is presented as a group of people, who make her do something she is not willing to. Uncertainty, inability to defend personal choices, doubts - do I have the right to be "selfish" by insisting on my choice of

Coping as a process Family relationships as problematic Loss of future /expected self Excessive thinking (Rumination) Time period	crying - as she and my dad are very good parents to me and my sister. Even at hard times we had everything we could wish for – pets, nice clothes, lovely holidays. I dread the moment when she (the mother) will say to me: "You have failed us, we gave you everything and what you have done is unacceptable". You see, one of us, me or my sister will have to keep the tradition alive, but she did not perform well in school because of her learning difficulties, so it is entirely up to me. And I do not want to feel guilty. But I cannot be a bad daughter either. Once my mum caught me smoking a cigarette and I will never forget the look on her face – I promised her I would never do it again and I haven't. A cigarette is just a one-off, but a choice of career is for life, so I can not disappoint them. My biggest fear is losing their approval and love – this is something I will not be able to live with. One day when my parents are gone, I will probably have to support my sister and I need to be well-off financially – in this country vets are not paid very much, so it is not a wise choice of profession. - Are you afraid of anything else? - No, I just do not want them to find out about my fears...yet, as I am not ready to tell them.	career? Moral, traditions and obedience Procrastination plus more intense physical descriptions of emotion *"Do not come out", "do not want" – it is a feeling of hopelessness and lack of choice which ties linguistically with the very beginning of the transcript* She is justifying her obligation to be an obedient daughter – by "returning" the sacrifices, made by parents. Surprisingly unemotional when talking about childhood – focusing on material things as signs of happy times, not on emotional closeness. *"You see" –looking for assurance that ignoring oneself is the only way to be thought of as a good daughter.* Pressure, taking the responsibility instead of her ill sister. More fear, promises and a poignant episode where a small disappointment was met with a level of disapproval she felt unable to deal with Identifies herself only as a part of the family – daughter and sister. Cannot imagine living outside the family cocoon. Safety and comfort zone Tries to diminish her original choice of career

	- Our conversation is confidential, Anna. Thank you for your help.	(sour grapes) in order to convince herself it was not an appropriate one and achieve piece with herself
Self-sacrifice		Preoccupied with materialistic thoughts Fear of parental disappointment is woven into the transcript.
Work on managing the self		*Lots of pauses in this part, hesitance - she did not know how to formulate the fear of being "caught out"*
Time period		What she has just disclosed made her feel vulnerable so she needed lots or reassurance.
The interdependent self		
Excessive thinking (Rumination)		

Family relationships as problematic		

Appendix XIX: Initial notes and emergent themes for Stephen, 17

Emergent themes	Original transcript	Exploratory comments
Excessive thinking Time period Undesirable feelings	-Hi Stephen, I would like you to tell me how does anxiety make you feel? -Restless and insecure. Filled with negative emotions and fears. Scared about everyone close to me and about what might happen tomorrow. I love my family and friends very much and I do not want anything bad to happen to them. But this world is filled with different dangers and frustrating people and this is what scares me most.	Anxiety has an overwhelming nature Uncertainty <u>Emphasis is placed on others</u>, not so much on internal <u>feelings</u> *Language emphasises darkness – 'bad', negative', 'dangers'* Separates 'dangers' and 'people', does not elaborate on what he means by 'frustrating' *Uses 'and'*

Work on managing the self Academic perspective The independent self	- What situations and people might make you feel anxious? - When I was younger I was scared of some of the older boys in our school. They looked quite menacing and rude and they were nasty to younger children. I am obviously not afraid anymore, because I am seventeen now. I am anxious about my exam results, because I want to go to a good university and become a scientist. I do not want to go stay in this town, as there are not many perspectives around. A lot of the people do	*frequently as if he makes lists all the time, as well as strong words – 'most', 'filled', 'very much'* School climate not healthy *Strong adjectives 'menacing', 'rude', 'nasty'* Wants to dissociate from childhood. Sees it as sign of weakness and vulnerability *Uses "I" a lot more often when talking about the future* Staying in home town is not an attractive opportunity. Is there more to the

Unwanted self is rejected The independent self Self-control Pro-social behaviour	unexciting administration work or work in different factories, petrol stations and supermarkets. This is not a life I want for myself or for my future family. In fact, I am quite scared that I might fail and end up having a boring life and a small salary. Another thing that scares me in this country is corruption – my grandmother was ill and the doctors demanded a lot of money to look after her. From what I have heard from other people, it is actually quite a common practice – not many people talk about it,	willingness to escape from birthplace? Very particular and precise about what he wants to **avoid** for his future, not so much about what he wants to **achieve.** Emphasis is placed on the wish to distinguish himself from the people with the boring jobs and lives. Failure equals lack of money – materialistic approach Political awareness, which was rare in other interviews. Family influence? Ties his disappointment and discouragement from the way things are

Self-perception Family relationships as problematic Dynamics of relationships in the	but everyone knows that it is happening. I do not want to be unable to help to my dearest people, because of financial difficulties. Sometimes I even consider leaving the country, because I think life is different elsewhere. -What other situations and people might make you feel anxious? - I dislike people who are unable to control their emotions – people who shout abuse and make everyone's life a misery make me very anxious indeed. I am usually a very calm person and I	happening in Bulgaria with his family and friends' experiences. Sees money as the only way forward – and wants to pursue career and money to secure a better life, but not to fight corruption or to change society. Lack of idealism – immigration is seen as an easier option. *"Elsewhere" – not mentioning any place in particular,* probably no research has been done, or he has not considered it seriously. Follows masculine models – emotions should be controlled. Appears

family Intensity of engagement in controlling behaviour Pro-social behaviour The interdependent self	resolve all of my problems reasonably and in a good manner. Girls also make me feel anxious sometimes, but that is because I cannot understand their way of thinking. Most of them appear quite moody and spoilt and they do not know what they want and how to ask others to do something for them. I find communication with this sort of people quite tiresome sometimes. Me and my sister who is only a year younger occasionally get on each other's nerves. Ever since we were little my parents have	very vague and cautious to show any personal involvement – '*people', 'girls'*, as if it happens to others, not himself. Values – composure and civilised approach. Portrays himself as possessing qualities he values. Fear of the unknown and devaluation of the opposite gender. Shows lack of support for inconsistent behaviour. Does not want to put an effort into communicating with people who express particular traits. Elaborates on

Self-ownership	taught me to be kind to her and to let her have things her own way, because I am the older one and I am a boy. I should make her feel safe and protected – and no matter how annoying she can be, I still do it, as it is my duty. And I fear something bad will happen to her if I don't. Her first love was an absolute waste of space – he was mixing with the wrong crowd and creating a lot of trouble. I did not want this kind of influence on her, my parents were not keen on him either. Luckily it is all	relationship with sister, which leads to insight into family values. The older brother – the protector, the one who has to look after younger sister, sometimes at the expense of his own preferences and wishes. Obligation, moral duty, willingness to be seen as a family hero. Shows the anxiety related to his little sister's wellbeing is not unfounded. Distinguishes himself from undesired and problematic

	resolved now and they have separated, but if something bad happens to her, I would feel personally responsible. I want the best for her. If I leave the town or the country I will not be able to look after her properly and that makes me feel guilty. She is not ambitious enough and has not considered leaving our town, but at the same time I am not prepared to sacrifice my dreams, so I am worried about what the future has in store for us... -Thank you very much for your help, Stephen.	behaviour Family also expresses similar values Sense of satisfaction and personal contribution to his sister's separation with the boyfriend who was deemed unsuitable Personal responsibility, perhaps interference and control?, desire to protect conflicts with his own plans for the future Sister's judgement and abilities to look after herself and make appropriate choices are underestimated Personal choice prevails, but

		the amount of anxiety is increasing. A result of instilling family obligation?

BIBLIOGRAPHY

Adcock, P. K. (2008). Evolution of teaching and learning through technology. *The Delta Kappa Gamma Bulletin, 74*(4), 37.

Ahmad, Z. R., Bano, N., Ahmad, R., and Khanam, S. J. (2013). Social anxiety in adolescents: does self esteem matter. *Asian journal of social sciences and humanities*, *2*(2), 91-98.

Akin, A., and Çetin, B. (2007). The Depression Anxiety and Stress Scale (DASS): The study of validity and reliability. *Kuram ve Uygulamada Egitim Bilimleri*, *7*(1), 260.

Almeida, O. P., Draper, B., Snowdon, J., Lautenschlager, N. T., Pirkis, J., Byrne, G., ... and Pfaff, J. J. (2012). Factors associated with suicidal thoughts in a large community study of older adults. *The British Journal of Psychiatry*,*201*(6), 466-472.

Anderson, J. C., Williams, S., McGee, R., and Silva, P. A. (1987). DSM-III disorders in preadolescent children: Prevalence in a large sample from the general population. *Archives of general psychiatry*, *44*(1), 69-76.

Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., and Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological assessment*, *10*(2), 176.

Anxiety. (n.d.) *Gale Encyclopedia of Medicine*. (2008). Retrieved September 24 2015 from http://medicaldictionary.thefreedictionary.com/anxiety

Anxiety. (n.d.) *The American Heritage® Medical Dictionary*. (2007). Retrieved September 24 2015 from http://medicaldictionary.thefreedictionary.com/anxiety

Apter, T. (1990) Altered loves: Mothers and daughters during adolescence. *New York: St Martin's Press.*

Arbuckle, J., Wothke, W. (1999) AMOS User's Guide 4.0, 1999, *Smallwaters, Chicago*

Balswick, J. O., and Macrides, C. (1975). Parental stimulus for adolescent rebellion. *Adolescence*.

Bandalos, D. L. (2008). Is parceling really necessary? A comparison of results from item parceling and categorical variable methodology. *Structural Equation Modeling*, *15*(2), 211-240.

Barker, G., Olukoya, A., and Aggleton, P. (2005). Young people, social support and help-seeking. *International journal of adolescent medicine and health*,*17*(4), 315-336.

Barkmann, C., Erhart, M., Schulte-Markwort, M., and BELLA Study Group. (2008). The German version of the Centre for Epidemiological Studies Depression Scale for Children: psychometric evaluation in a population-based survey of 7 to 17 years old children and adolescents–results of the BELLA study. *European child and adolescent psychiatry*, *17*(1), 116-124.

Barney, L. J., Griffiths, K. M., Christensen, H., and Jorm, A. F. (2009). Exploring the nature of stigmatising beliefs about depression and help-seeking: implications for reducing stigma. *BMC public health*, *9*(1), 61.

Barney, L. J., Griffiths, K. M., Jorm, A. F., and Christensen, H. (2006). Stigma about depression and its impact on help-seeking intentions. *Australian and New Zealand Journal of Psychiatry*, *40*(1), 51-54.

Baron, R. M., and Kenny, D. A. (1986). The moderator–mediator variable distinction in social psychological research: Conceptual, strategic, and statistical considerations. *Journal of personality and social psychology*,*51*(6), 1173.

Bauer, T. K., and Zimmermann, K. F. (1999). *Assessment of possible migration pressure and its labour market impact following EU enlargement to Central and Eastern Europe* (Vol. 3). Bonn:

Baumeister, R. E., and Tice, D. M. (1986). Four selves, two motives, and a substitute process self-regulation model. In *Public self and private self* (pp. 63-74). Springer New York.

Beck, J. C., and Worthen, K. (1972). Precipitating stress, crisis theory, and hospitalization in schizophrenia and depression. *Archives of General Psychiatry*, *26*(2), 123-129.

Beesdo, K., Knappe, S., and Pine, D. S. (2009). Anxiety and anxiety disorders in children and adolescents: developmental issues and implications for DSM-V. *Psychiatric Clinics of North America*, *32*(3), 483-524.

Ben-Porath, D. D. (2002). Stigmatization of individuals who receive psychotherapy: An interaction between help-seeking behavior and the presence of depression. *Journal of Social and Clinical psychology*, *21*(4), 400-413.

Bentler, P. M. (1990). Comparative fit indexes in structural models.*Psychological bulletin*, *107*(2), 238.

Bentler, P. M., and Bonett, D. G. (1980). Significance tests and goodness of fit in the analysis of covariance structures. *Psychological bulletin*, *88*(3), 588.

Bernstein, D. P., Ahluvalia, T., Pogge, D., and Handelsman, L. (1997). Validity of the Childhood Trauma Questionnaire in an adolescent psychiatric population. *Journal of the American Academy of Child and Adolescent Psychiatry*, *36*(3), 340-348.

Blakemore, S. J. (2008). The social brain in adolescence. *Nature Reviews Neuroscience*, *9*(4), 267-277.

Bland, R. C., Orn, H., and Newman, S. C. (1988). Lifetime prevalence of psychiatric disorders in Edmonton. *Acta Psychiatrica Scandinavica*,*77*(S338), 24-32.

Blos, P. (1962). Intensive psychotherapy in relation to the various phases of the adolescent period. *American Journal of Orthopsychiatry*, *32*(5), 901.

Bodeker, G., and Kronenberg, F. (2002). A public health agenda for traditional, complementary, and alternative medicine. *American journal of public health*,*92*(10), 1582-1591.

Bogdan, R., and Taylor, S. J. (1990). Looking at the bright side: A positive approach to qualitative policy and evaluation research. *Qualitative Sociology*, *13*(2), 183-192.

Boldero, J., and Fallon, B. (1995). Adolescent help-seeking: What do they get help for and from whom?. *Journal of Adolescence*, *18*(2), 193-209.

Borissov, V., and Rathwell, T. (1996). Health care reforms in Bulgaria: an initial appraisal. *Social Science and Medicine*, *42*(11), 1501-1510.

Borkovec, T. D. (1994). The nature, functions, and origins of worry.

Bourdon, K. H., Boyd, J. H., Rae, D. S., Burns, B. J., Thompson, J. W., and Locke, B. Z. (1988). Gender differences in phobias: results of the ECA community survey. *Journal of Anxiety Disorders*, *2*(3), 227-241.

Bourdon, K. H., Boyd, J. H., Rae, D. S., Burns, B. J., Thompson, J. W., and Locke, B. Z. (1988). Gender differences in phobias: results of the ECA community survey. *Journal of Anxiety Disorders*, *2*(3), 227-241.

Bourdon, K. H., Goodman, R., Rae, D. S., Simpson, G., and Koretz, D. S. (2005). The Strengths and Difficulties Questionnaire: US normative data and psychometric properties. *Journal of the American Academy of Child and Adolescent Psychiatry*, *44*(6), 557-564.

Brenick, A., Killen, M., Lee-Kim, J., Fox, N., Leavitt, L., Raviv, A., ... and Al-Smadi, Y. (2010). Social understanding in young Israeli-Jewish, Israeli-Palestinian, Palestinian, and Jordanian children: Moral judgments and stereotypes. *Early education and development*, *21*(6), 886-911.

Brody, L. R., and Hall, J. A. (2008). Gender and emotion in context. *Handbook of emotions*, *3*, 395-408.

Brown, T. A., Chorpita, B. F., Korotitsch, W., and Barlow, D. H. (1997). Psychometric properties of the Depression Anxiety Stress Scales (DASS) in clinical samples. *Behaviour research and therapy*, *35*(1), 79-89.

Burns, J. R., and Rapee, R. M. (2006). Adolescent mental health literacy: young people's knowledge of depression and help seeking. *Journal of adolescence*, *29*(2), 225-239.

Carlo, G., Mestre, M. V., McGinley, M. M., Samper, P., Tur, A., and Sandman, D. (2012). The interplay of emotional instability, empathy, and coping on prosocial and aggressive behaviors. *Personality and Individual Differences*,*53*(5), 675-680.

Carlson Jones, D. (2004). Body image among adolescent girls and boys: a longitudinal study. *Developmental psychology*, *40*(5), 823.

Carter, A. S., Pollock, R. A., Suvak, M. K., and Pauls, D. L. (2004). Anxiety and major depression comorbidity in a family study of obsessive–compulsive disorder. *Depression and Anxiety*, *20*(4), 165-174.

Cartwright-Hatton S., McNicol, K., Doubleday, E. (2006). Anxiety in a neglected population: Prevalence of anxiety disorders in pre-adolescent children. *Clinical Psychology Review 26*(7):817-833.

Casey, B. J., Jones, R. M., and Hare, T. A. (2008). The adolescent brain. *Annals of the New York Academy of Sciences*, *1124*(1), 111-126.

Chao, R. (1995). Chinese and European American cultural model of the self-reflected in mothers' childrearing beliefs, *Ethos*, 23, 328-354.

Chavdarova, T. (2001). Corruption in the Bulgarian post-communist transformation. *SEER-South-East Europe Review for Labour and Social Affairs*, (03), 9-18.

Christie, D., and Viner, R. (2005). Adolescent development. *Bmj*, *330*(7486), 301-304.

Clancy, S. M., and Dollinger, S. J. (1993). Identity, self, and personality: I. Identity status and the five-factor model of personality. *Journal of Research on Adolescence*, *3*(3), 227-245.

Clara, I. P., Cox, B. J., and Enns, M. W. (2001). Confirmatory factor analysis of the Depression–Anxiety–Stress Scales in depressed and anxious patients.*Journal of psychopathology and behavioral assessment*, *23*(1), 61-67.

Cohen, J. (1992). A power primer. *Psychological bulletin*, *112*(1), 155.

Cohen, P., Cohen, J., Kasen, S., Velez, C. N., Hartmark, C., Johnson, J., and Streuning, E. L. (1993). An epidemiological study of disorders in late childhood and adolescence—I. Age-and Gender-Specific Prevalence.*Journal of Child Psychology and Psychiatry*, *34*(6), 851-867.

Coleman, J. C., and Hendry, L. B. (1999). *The nature of adolescence*. Psychology Press.

Conger, R. D., Rueter, M. A., and Elder Jr, G. H. (1999). Couple resilience to economic pressure. *Journal of personality and social psychology*, *76*(1), 54.

Cornia, G. A., and Paniccià, R. (Eds.). (2000). *The mortality crisis in transitional economies*. Oxford University Press.

Corrigan, P. (2004). How stigma interferes with mental health care. *American psychologist*, *59*(7), 614.

Costello, E. J., Mustillo, S., Erkanli, A., Keeler, G., and Angold, A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of general psychiatry*, *60*(8), 837-844.

Cotton, S. M., Wright, A., Harris, M. G., Jorm, A. F., and McGorry, P. D. (2006). Influence of gender on mental health literacy in young Australians. *Australian and New Zealand Journal of Psychiatry*, *40*(9), 790-796.

Crane Amaya, A., and Campbell, M. A. (2010). Cross-cultural comparison of anxiety symptoms in Colombian and Australian children. *Electronic Journal of Research in Educational Psychology*, *8*(2), 497-516.

Crawford, J. R., and Henry, J. D. (2003). The Depression Anxiety Stress Scales (DASS): Normative data and latent structure in a large non-clinical sample. *British Journal of Clinical Psychology*, *42*(2), 111-131.

Creswell, J. W., and Clark, V. L. P. (2007). Designing and conducting mixed methods research.

Croghan, T. W., Tomlin, M., Pescosolido, B. A., Schnittker, J., Martin, J., Lubell, K., and Swindle, R. (2003). American attitudes toward and willingness to use psychiatric medications. *The Journal of nervous and mental disease*,*191*(3), 166-174.

Cross, S. E., and Madson, L. (1997). Models of the self: self-construals and gender. *Psychological bulletin*, *122*(1), 5.

Cullen, J., and Bryman, A. (1988) "The knowledge acquisition bottleneck: time for reassessment?" *Expert Systems* 5.3 : 216-225.

Currall, S. C., Hammer, T. H., Baggett, L. S., and Doniger, G. M. (1999). Combining Qualitative and Quantitative Methodologies to Study Group Processes: An Illustrative Study of Acorporate Board of Directors.*Organizational Research Methods*, *2*(1), 5-36.

Dahlberg, K. M., Waern, M., and Runeson, B. (2008). Mental health literacy and attitudes in a Swedish community sample–Investigating the role of personal experience of mental health care. *BMC Public Health*, *8*(1), 8.

Dahlin, M., Joneborg, N., and Runeson, B. (2005). Stress and depression among medical students: A cross-sectional study. *Medical education*, *39*(6), 594-604.

Davies, H. T., Nutley, S. M., and Mannion, R. (2000). Organisational culture and quality of health care. *Quality in Health Care*, *9*(2), 111-119.

Deal, T. E., and Kennedy, A. A. (1982). Corporate cultures: The rites and rituals of organizational life. *Reading/T. Deal, A. Kennedy.–Mass: Addison-Wesley*, 98-103.

Deen, T. L., and Bridges, A. J. (2011). Depression literacy: rates and relation to perceived need and mental health service utilization in a rural American sample. *Rural Remote Health*, *11*(4), 1803.

Derks, J., and Krabbendam, L. (2013). Is the Brain the Key to a Better Understanding of Gender Differences in the Classroom? *International Journal of Gender, Science and Technology*, *5*(3), 281-291.

Desjarlais, R. (1996). *World mental health: problems and priorities in low-income countries*. Oxford University Press, USA.

Dinos, S., Stevens, S., Serfaty, M., Weich, S., and King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness Qualitative study.*The British Journal of Psychiatry*, *184*(2), 176-181.

Eagly, A. H., and Steffen, V. J. (1984). Gender stereotypes stem from the distribution of women and men into social roles. *Journal of personality and social psychology*, *46*(4), 735.

Eatough, V., Smith, J. A., and Shaw, R. (2008). Women, anger, and aggression an interpretative phenomenological analysis. *Journal of interpersonal violence*, *23*(12), 1767-1799.

Ebesutani, C., Bernstein, A., Martinez, J. I., Chorpita, B. F., and Weisz, J. R. (2011). The Youth Self Report: Applicability and validity across younger and older youths. *Journal of Clinical Child and Adolescent Psychology*, *40*(2), 338-346.

Edwards, K. R., Martin, R. A., and Dozois, D. J. (2010). The fear of being laughed at, social anxiety, and memories of being teased during childhood.*Psychology Science Quarterly*, *52*(1), 94.

Eley, T. C., Stirling, L., Ehlers, A., Gregory, A. M., and Clark, D. M. (2004). Heart-beat perception, panic/somatic symptoms and anxiety sensitivity in children.*Behaviour research and therapy*, *42*(4), 439-448.

Erikson, E. H. (1968). *Identity: Youth and crisis*. New York: Norton.

Essau, C. A., Anastassiou-Hadjicharalambous, X., and Muñoz, L. C. (2011). Psychometric properties of the Spence Children's Anxiety Scale (SCAS) in Cypriot children and adolescents. *Child Psychiatry and Human Development*,*42*(5), 557-568.

Essau, C. A., Conradt, J., and Petermann, F. (1999). Frequency and comorbidity of social phobia and social fears in adolescents. *Behaviour research and therapy*, *37*(9), 831-843.

Essau, C. A., Conradt, J., and Petermann, F. (2000). Frequency, comorbidity, and psychosocial impairment of anxiety disorders in German adolescents.*Journal of anxiety disorders*, *14*(3), 263-279.

Essau, C. A., Leung, P. W., Conradt, J., Cheng, H., and Wong, T. (2008). Anxiety symptoms in Chinese and German adolescents: Their relationship with early learning experiences, perfectionism, and learning motivation. *Depression and Anxiety*, *25*(9), 801-810.

Essau, C. A., Leung, P. W., Conradt, J., Cheng, H., and Wong, T. (2008). Anxiety symptoms in Chinese and German adolescents: Their relationship with early

learning experiences, perfectionism, and learning motivation. *Depression and Anxiety*, *25*(9), 801-810.

Essau, C. A., Lewinsohn, P. M., Olaya, B., and Seeley, J. R. (2014). Anxiety disorders in adolescents and psychosocial outcomes at age 30. *Journal of Affective Disorders.*

Essau, C. A., Muris, P., and Ederer, E. M. (2002). Reliability and validity of the Spence Children's Anxiety Scale and the Screen for Child Anxiety Related emotional disorders in German children. *Journal of Behavior Therapy and Experimental Psychiatry*, *33*(1), 1-18.

Essau, C. A., Sasagawa, S., Anastassiou-Hadjicharalambous, X., Guzmán, B. O., and Ollendick, T. H. (2011). Psychometric properties of the Spence Child Anxiety Scale with adolescents from five European countries. *Journal of anxiety disorders*, *25*(1), 19-27.

Essau, C., and Petermann, F. (2001). *Anxiety disorders in children and adolescents: Epidemiology, risk factors and treatment* (Vol. 4). Psychology Press.

Fabes, R. A., and Martin, C. L. (1991). Gender and age stereotypes of emotionality. *Personality and social psychology bulletin*, *17*(5), 532-540.

Faravelli, C., Scarpato, M. A., Castellini, G., and Sauro, C. L. (2013). Gender differences in depression and anxiety: the role of age. *Psychiatry research*,*210*(3), 1301-1303.

Faulstich, M. E., Carey, M. P., Ruggiero, L., Enyart, P., and Gresham, F. (1986). Assessment of depression in childhood and adolescence: An evaluation of the Center for Epidemiological Studies Depression Scale for Children (CES-DC). *The American journal of psychiatry*.

Feehan, M., McGee, R., and Williams, S. M. (1993). Mental health disorders from age 15 to age 18 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, *32*(6), 1118-1126.

Fernández, I., Paez, D., and González, J. L. (2005). Independent and interdependent self-construals and socio-cultural factors in 29 nations.*Revue Internationale de psychologie sociale*, *18*(1), 35-63.

Finkenauer, C., Engels, R. C., and Baumeister, R. F. (2005). Parenting behaviour and adolescent behavioural and emotional problems: The role of self-control. *International Journal of Behavioral Development*, *29*(1), 58-69.

Fleischer-Mann, J. (1995). Exploration of attachment-separation, fear of death and separation anxiety in agoraphobia, *Dissertation Abstracts International, Section B: The Sciences and Engineering*, Volume 56, Page 2370

Ganasen, K. A., Parker, S., Hugo, C. J., Stein, D. J., Emsley, R. A., and Seedat, S. (2008). Mental health literacy: focus on developing countries: review article. *African Journal of Psychiatry*, *11*(1), 23-28.

Gasquet, I., Chavance, M., Ledoux, S., and Choquet, M. (1997). Psychosocial factors associated with help-seeking behavior among depressive adolescents. *European child and adolescent psychiatry*, *6*(3), 151-159.

Gater, R., Jordanova, V., Maric, N., Alikaj, V., Bajs, M., Cavic, T., ... and Sartorius, N. (2005). Pathways to psychiatric care in Eastern Europe. *The British Journal of Psychiatry*, *186*(6), 529-535.

Gecková, A., Van Dijk, J. P., Stewart, R., Groothoff, J. W., and Post, D. (2003). Influence of social support on health among gender and socio-economic groups of adolescents. *The European Journal of Public Health*, *13*(1), 44-50.

Ginsburg, G. S., Riddle, M. A., and Davies, M. (2006). Somatic symptoms in children and adolescents with anxiety disorders. *Journal of the American Academy of Child and Adolescent Psychiatry*, *45*(10), 1179-1187.

Given, L. M. (Ed.). (2008). *The Sage encyclopaedia of qualitative research methods*. Sage Publications.

Goffman, E. (1963) *Stigma: Notes on the Management of Spoiled Identity*. Engelwood Cliffs, NJ: Prentice-Hall.

Goldney, R. D., Fisher, L. J., and Wilson, D. H. (2001). Mental health literacy: an impediment to the optimum treatment of major depression in the community.*Journal of affective disorders*, *64*(2), 277-284.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: a research note. *Journal of child psychology and psychiatry*, *38*(5), 581-586.

Goodman, R., Ford, T., Simmons, H., Gatward, R., and Meltzer, H. (2000). Using the Strengths and Difficulties Questionnaire (SDQ) to screen for child psychiatric disorders in a community sample. *The British Journal of Psychiatry*, *177*(6), 534-539.

Graham, E., and Jordan, L. P. (2011). Migrant Parents and the Psychological Well-Being of Left-Behind Children in Southeast Asia. *Journal of Marriage and Family*, *73*(4), 763-787.

Greatbatch, D., Murphy, E., and Dingwall, R. (2001). Evaluating medical information systems: ethnomethodological and interactionist approaches.*Health Services Management Research*, *14*(3), 181-191.

Greenberg, J., Pyszczynski, T., and Solomon, S. (1986). The causes and consequences of a need for self-esteem: A terror management theory. In*Public self and private self* (pp. 189-212). Springer New York.

Gregory, R. G. (1999). Children and the changing labour market: Joblessness in families with dependent children. *Made available in DSpace on 2011-01-05T08: 24: 59Z (GMT). Previous issue date: 2004-05-19T06: 39: 27Z.*

Griffiths, K. M., Crisp, D. A., Jorm, A. F., and Christensen, H. (2011). Does stigma predict a belief in dealing with depression alone?. *Journal of affective disorders*, *132*(3), 413-417.

Halpern-Felsher, B. L., and Cauffman, E. (2001). Costs and benefits of a decision: Decision-making competence in adolescents and adults. *Journal of Applied Developmental Psychology*, *22*(3), 257-273.

Hammen, C. (2005). Stress and depression. *Annu. Rev. Clin. Psychol., 1*, 293-319.

Hankin, B. L., Mermelstein, R., and Roesch, L. (2007). Sex differences in adolescent depression: Stress exposure and reactivity models. *Child development*, *78*(1), 279-295.

Hardin, E. E. (2006). Convergent evidence for the multidimensionality of self-construal. *Journal of Cross-cultural psychology*, *37*(5), 516-521.

Hawes, D. J., and Dadds, M. R. (2004). Australian data and psychometric properties of the Strengths and Difficulties Questionnaire. *Australian and New Zealand Journal of Psychiatry*, *38*(8), 644-651.

Hayes, J. Schimel, J. Arndt and Faucher. E. (2010) A theoretical and empirical review of the death-thought accessibility concept in terror management research. *Psychological Bulletin*, 136 (2010), pp. 699–739

Helsen, M., Vollebergh, W., and Meeus, W. (2000). Social support from parents and friends and emotional problems in adolescence. *Journal of Youth and Adolescence*, *29*(3), 319-335.

Holmes, T. H., and Rahe, R. H. (1967). The social readjustment rating scale.*Journal of psychosomatic research*, *11*(2), 213-218.

Hudson, J. L., and Rapee, R. M. (2001). Parent–child interactions and anxiety disorders: An observational study. *Behaviour research and therapy*, *39*(12), 1411-1427.

Huerta, R., and Brizuela-Gamiño, O. L. (2002). Interaction of pubertal status, mood and self-esteem in adolescent girls. *The Journal of reproductive medicine*, *47*(3), 217-225.

Hugo, C. J., Boshoff, D. E., Traut, A., Zungu-Dirwayi, N., and Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa.*Social psychiatry and psychiatric epidemiology*, *38*(12), 715-719.

Ishikawa, S. I., Sato, H., and Sasagawa, S. (2009). Anxiety disorder symptoms in Japanese children and adolescents. *Journal of Anxiety Disorders*, *23*(1), 104-111.

Iverach, L., Menzies, R. G., and Menzies, R. E. (2014). Death anxiety and its role in psychopathology: Reviewing the status of a transdiagnostic construct.*Clinical psychology review*, *34*(7), 580-593.

Jaycox, L. H., Reivich, K. J., Gillham, J., and Seligman, M. E. (1994). Prevention of depressive symptoms in school children. *Behaviour research and therapy*, *32*(8), 801-816.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about. *British Journal of Psychiatry*, *177*, 396-401.

Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about. *British Journal of Psychiatry*, *177*, 396 Mayers, C., Leavey, G., Vallianatou, C., and Barker, C. (2007). How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study. *Clinical Psychology and Psychotherapy*, *14*(4), 317-327.-401.

Jorm, A. F., and Griffiths, K. M. (2006). Population promotion of informal self-help strategies for early intervention against depression and anxiety.*Psychological medicine*, *36*(01), 3-6.

Jorm, A. F., Kelly, C. M., Wright, A., Parslow, R. A., Harris, M. G., and McGorry, P. D. (2006). Belief in dealing with depression alone: results from community surveys of adolescents and adults. *Journal of affective disorders*, *96*(1), 59-65.

Jorm, A. F., Korten, A. E., Jacomb, P. A., Christensen, H., Rodgers, B., and Pollitt, P. (1997). 'Mental health literacy. *a survey of the public's ability to recognise mental disorders and their beliefs about the effectiveness of treatment. Med J Aust*, *166*(4), 182-186.

Jorm, A. F., Morgan, A. J., and Wright, A. (2010). Actions that young people can take to prevent depression, anxiety and psychosis: beliefs of health professionals and young people. *Journal of affective disorders*, *126*(1), 278-281.

Jorm, A. F., Nakane, Y., Christensen, H., Yoshioka, K., Griffiths, K. M., and Wata, Y. (2005). Public beliefs about treatment and outcome of mental disorders: a comparison of Australia and Japan. *BMC medicine*, *3*(1), 12.

Kadam, U. T., Croft, P., McLeod, J., and Hutchinson, M. (2001). A qualitative study of patients' views on anxiety and depression. *British Journal of General Practice*, *51*(466), 375-380.

Kaneff, D. (2002). Why People Don't Die 'Naturally'any More: Changing Relations Between 'The Individual'and 'The State'in Post-Socialist Bulgaria.*Journal of the Royal Anthropological Institute*, *8*(1), 89-105.

Kaplan, H. B., Martin, S. S., and Robbins, C. (1984). Pathways to adolescent drug use: Self-derogation, peer influence, weakening of social controls, and early substance use. *Journal of Health and Social Behavior*, 270-289.

Keller, M. B., Lavori, P. W., Wunder, J., Beardslee, W. R., Schwartz, C. E., and Roth, J. (1992). Chronic course of anxiety disorders in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *31*(4), 595-599.

Keller, M. B., Lavori, P. W., Wunder, J., Beardslee, W. R., Schwartz, C. E., and Roth, J. (1992). Chronic course of anxiety disorders in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *31*(4), 595-599.

Kelly, C. M., Jorm, A. F., and Wright, A. (2007). Improving mental health literacy as a strategy to facilitate early intervention for mental disorders. *Med J Aust*,*187*(7 Suppl), S26-30.

Kemmelmeier, M., Burnstein, E., Krumov, K., Genkova, P., Kanagawa, C., Hirshberg, M. S., ... and Noels, K. A. (2003). Individualism, collectivism, and authoritarianism in seven societies. *Journal of Cross-Cultural Psychology*,*34*(3), 304-322.

Kessler, R. C., Amminger, G. P., Aguilar-Gaxiola, S., Alonso, J., Lee, S., and Ustun, T. B. (2007). Age of onset of mental disorders: a review of recent literature. *Current opinion in psychiatry*, *20*(4), 359.

Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., and Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders

in the National Comorbidity Survey Replication. *Archives of general psychiatry*, *62*(6), 593-602.

Kessler, R. C., Davis, C. G., and Kendler, K. S. (1997). Childhood adversity and adult psychiatric disorder in the US National Comorbidity Survey.*Psychological medicine*, *27*(05), 1101-1119.

Kessler, R. C., McGonagle, K. A., Zhao, S., Nelson, C. B., Hughes, M., Eshleman, S. and Kendler, K. S. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: results from the National Comorbidity Survey. *Archives of general psychiatry*, *51*(1), 8-19.

Kilpatrick Demaray, M., and Kerres Malecki, C. (2003). Perceptions of the Frequency and Importance of Social Support by Students Classified as Victims, Bullies, and Bully/Victims in an Urban Middle School. *School Psychology Review*.

Kim, H. S., Sherman, D. K., and Taylor, S. E. (2008). Culture and social support.*American Psychologist*, *63*(6), 518.

Klein, D. N., Glenn, C. R., Kosty, D. B., Seeley, J. R., Rohde, P., and Lewinsohn, P. M. (2013). Predictors of first lifetime onset of major depressive disorder in young adulthood. *Journal of abnormal psychology*, *122*(1), 1.

Koff, E., and Sangani, P. (1997). Effects of coping style and negative body image on eating disturbance. *International Journal of Eating Disorders*,*22*(1), 51-56.

Korolenko, C. P., and Kensin, D. V. (2002). Reflections on the past and present state of Russian psychiatry. *Anthropology and Medicine*, *9*(1), 51-64.

Koteskey, R. L., Little, M. D., and Matthews, M. V. (1991). Adolescent identity and depression. *Journal of Psychology and Christianity*.

Laceulle, O. M., Ormel, J., Vollebergh, W. A., Aken, M. A., and Nederhof, E. (2014). A test of the vulnerability model: temperament and temperament change as predictors of future mental disorders–the TRAILS study. *Journal of Child Psychology and Psychiatry*, *55*(3), 227-236.

Lam, L. (2014). Mental health literacy and mental health status in adolescents: a population-based survey**.** *Child and Adolescent Psychiatry and Mental Health* 2014, **8**:26 doi:10.1186/1753-2000-8-26

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method*. Pearson Education.

Langs, R. (2004). Death Anxiety and the Emotion-Processing Mind.*Psychoanalytic Psychology*, *21*(1), 31.

Lauber, C., and Rössler, W. (2007). Stigma towards people with mental illness in developing countries in Asia. *International review of psychiatry*, *19*(2), 157-178.

Lefterova, B. (2014). Health Education and its status in Bulgarian schools. *Sofia University Journal for Educational Research,* vol.1

Lenzenweger, M. F., Lane, M. C., Loranger, A. W., and Kessler, R. C. (2007). DSM-IV personality disorders in the National Comorbidity Survey Replication. *Biological psychiatry*, *62*(6), 553-564.

Lerner, R. M., and Steinberg, L. (2009). *Handbook of Adolescent Psychology, Individual Bases of Adolescent Development* (Vol. 1). John Wiley and Sons.

Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., and Andrews, J. A. (1993). Adolescent psychopathology: I. Prevalence and incidence of depression and other DSM-III—R disorders in high school students. *Journal of abnormal psychology*, *102*(1), 133.

López, E. J., and Salas, L. (2006). Assessing Social Support in Mexican and Mexican American High School Students A Validation Study. *Journal of Hispanic Higher Education*, *5*(2), 97-106.

Loureiro, L. M. J., Jorm, A. F., Oliveira, R. A., Mendes, A. M. O. C., dos Santos, J. C. P., Rodrigues, M. A., and Sousa, C. S. F. (2015). Mental health Literacy about schizophrenia: A survey of portuguese youth. *Early intervention in psychiatry*, *9*(3), 234-241.

Loureiro, L. M., Jorm, A. F., Mendes, A. C., Santos, J. C., Ferreira, R. O., and Pedreiro, A. T. (2013). Mental health literacy about depression: a survey of portuguese youth. *BMC psychiatry*, *13*(1), 129.

Lovibond, P. F., and Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour research and therapy*, *33*(3), 335-343.

Lutz, C. (1985). Depression and the translation of emotional worlds. *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*, 63-100.

Luyckx, K., Goossens, L., Soenens, B., and Beyers, W. (2006). Unpacking commitment and exploration: Preliminary validation of an integrative model of late adolescent identity formation. *Journal of adolescence*, *29*(3), 361-378.

Maes, M., Song, C., Lin, A., De Jongh, R., Van Gastel, A., Kenis, G., ... and Smith, R. S. (1998). The effects of psychological stress on humans: increased production of pro-inflammatory cytokines and Th1-like response in stress-induced anxiety. *Cytokine*, *10*(4), 313-318.

Magee, W. J., Eaton, W. W., Wittchen, H. U., McGonagle, K. A., and Kessler, R. C. (1996). Agoraphobia, simple phobia, and social phobia in the National Comorbidity Survey. *Archives of General Psychiatry*, *53*(2), 159-168.

Markus, H. R., and Kitayama, S. (1991). Culture and the self: Implications for cognition, emotion, and motivation. *Psychological review*, *98*(2), 224.

Maxfield, M., Pyszczynski, T., Kluck, B., Cox, C. R., Greenberg, J., Solomon, S., and Weise, D. (2007). Age-related differences in responses to thoughts of one's own death: mortality salience and judgments of moral transgressions. *Psychology and aging*, *22*(2), 341.

Maxwell, S. E., and Cole, D. A. (2007). Bias in cross-sectional analyses of longitudinal mediation. *Psychological methods*, *12*(1), 23.

Mays, N., and Pope, C. (2000). Qualitative research in health care: Assessing quality in qualitative research. *BMJ: British Medical Journal*, *320*(7226), 50.

McGee, R., Feehan, M., Williams, S., Partridge, F., Silva, P. A., and Kelly, J. (1990). DSM-III disorders in a large sample of adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, *29*(4), 611-619.

McHenry, J., Carrier, N., Hull, E., and Kabbaj, M. (2014). Sex differences in anxiety and depression: role of testosterone. *Frontiers in neuroendocrinology*, *35*(1), 42-57.

McLeod, D. R., Hoehn-Saric, R., and Stefan, R. L. (1986). Somatic symptoms of anxiety: comparison of self-report and physiological measures. *Biological psychiatry*, *21*(3), 301-310.

McNair, B., Highet, N., Hickie, I. and Davenport, T. (2002) Exploring the perspectives of people whose lives have been affected by depression. *Medical Journal of Australia;* 176: 69–76;

Mehta, K. M., Simonsick, E. M., Penninx, B. W., Schulz, R., Rubin, S. M., Satterfield, S., and Yaffe, K. (2003). Prevalence and correlates of anxiety symptoms in well-functioning older adults: Findings from the health aging and body composition study. *Journal of the American Geriatrics Society*,*51*(4), 499-504.

Merry, S., McDowell, H., Wild, C. J., Bir, J., and Cunliffe, R. (2004). A randomized placebo-controlled trial of a school-based depression prevention program. *Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(5), 538-547.

Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression.*Journal of affective disorders*, *71*(1), 1-9.

Mould-Quevedo, J. F., Tang, B., Harary, E., Kurzman, R., Pan, S., Yang, J., and Qiao, J. (2013). The burden of caring for dementia patients: caregiver reports from a cross-sectional hospital-based study in China.

Muris, P., Mayer, B., and Meesters, C. (2000). Self-reported attachment style, anxiety, and depression in children. *Social Behavior and Personality: an international journal*, *28*(2), 157-162.

Muris, P., Merckelbach, H., Ollendick, T., King, N., and Bogie, N. (2002). Three traditional and three new childhood anxiety questionnaires: Their reliability and validity in a normal adolescent sample. *Behaviour research and therapy*, *40*(7), 753-772.

Nantel-Vivier, A., Kokko, K., Caprara, G. V., Pastorelli, C., Gerbino, M. G., Paciello, M., and Tremblay, R. E. (2009). Prosocial development from childhood to adolescence: a multi-informant perspective with Canadian and Italian longitudinal studies. *Journal of child psychology and psychiatry,50*(5), 590-598.

Nasser, F., and Wisenbaker, J. (2003). A Monte Carlo study investigating the impact of item parceling on measures of fit in confirmatory factor analysis.*Educational and Psychological Measurement*, *63*(5), 729-757.

Nesse, R. E., and Finlayson, R. E. (1996). Management of depression in patients with coexisting medical illness. *American family physician*, *53*(6), 2125-2133.

Neuman, W. L., and Robson, K. (2004). *Basics of social research*. Pearson.

Newcomb, M. D. (1990). What structural equation modeling can tell us about social support.

Newman, I., and Benz, C. R. (1998). *Qualitative-quantitative research methodology: Exploring the interactive continuum*. SIU Press.

NOYES Jr, R., Stuart, S., Longley, S. L., Langbehn, D. R., and Happel, R. L. (2002). Hypochondriasis and fear of death. *The Journal of nervous and mental disease*, *190*(8), 503-509.

O'Brien-Pallas, L., Baumann, A., Donner, G., Murphy, G. T., Lochhaas-Gerlach, J., and Luba, M. (2001). Forecasting models for human resources in health care. *Journal of Advanced Nursing*, *33*(1), 120-129.

Olsson, D. P., and Kennedy, M. G. (2010). Mental health literacy among young people in a small US town: recognition of disorders and hypothetical helping responses. *Early Intervention in Psychiatry*, *4*(4), 291-298.

Orgilés, M., Méndez, X., Spence, S. H., Huedo-Medina, T. B., and Espada, J. P. (2012). Spanish validation of the Spence Children's Anxiety Scale. *Child Psychiatry and Human Development, 43*(2), 271-281.

Paulhus, D. L. (1991). Measurement and control of response bias.

Paulhus, D. L., and Vazire, S. (2007). The self-report method. *Handbook of research methods in personality psychology*, 224-239.

Pennebaker, J. W. (1982). *The psychology of physical symptoms*. James Pennebaker.

Phillips, K. A., McElroy, S. L., Hudson, J. I., and Pope, H. G. (1995). Body dysmorphic disorder: an obsessive-compulsive spectrum disorder, a form of affective spectrum disorder, or both?. *Journal of Clinical Psychiatry*.

Pine, D. S., Cohen, P., Gurley, D., Brook, J., and Ma, Y. (1998). The risk for early-adulthood anxiety and depressive disorders in adolescents with anxiety and depressive disorders. *Archives of general psychiatry*, *55*(1), 56-64.

Pollack, M. H., Otto, M. W., Sabatino, S., and Majcher, D. (1996). Relationship of childhood anxiety to adult panic disorder: correlates and influence on course. *The American journal of psychiatry*, *153*(3), 376.

Popova, S., Rehm, J., Patra, J., and Zatonski, W. (2007). Comparing alcohol consumption in central and eastern Europe to other European countries.*Alcohol and alcoholism*, *42*(5), 465-473.

Pössel, P., Horn, A. B., Groen, G., and Hautzinger, M. (2004). School-based prevention of depressive symptoms in adolescents: A 6-month follow-up.*Journal of the American Academy of Child and Adolescent Psychiatry*, *43*(8), 1003-1010.

Priest, R. G., Vize, C., Roberts, A., Roberts, M., and Tylee, A. (1996). Lay people's attitudes to treatment of depression: results of opinion poll for Defeat Depression Campaign just before its launch. *Bmj*, *313*(7061), 858-859.

Proffer, A. A. (1996). The interpersonal treatment of young children: Principles and techniques. *Psychotherapy: Theory, Research, Practice, Training*, *33*(1), 68.

Raleva, S., Yankov, B., Ruskov, P., Haralampiev, K., Mikova, E., Teplova, T., and Monov, V. (2014) Impact of Labour on the Economic Growth in Bulgaria (1991-2013).

Rasmussen, C. A., and Brems, C. (1996). The relationship of death anxiety with age and psychosocial maturity. *The Journal of psychology*, *130*(2), 141-144.

Rasmussen, S. A., and Eisen, J. L. (1992). The epidemiology and clinical features of obsessive compulsive disorder. *Psychiatric Clinics of North America*.

Raviv, A., Sills, R., Raviv, A., and Wilansky, P. (2000). Adolescents' help-seeking behaviour: The difference between self-and other-referral. *Journal of adolescence*, *23*(6), 721-740.

Regier, D. A., Rae, D. S., Narrow, W. E., Kaelber, C. T., and Schatzberg, A. F. (1998). Prevalence of anxiety disorders and their comorbidity with mood and addictive disorders. *The British Journal of Psychiatry*.

Reynders, A., Kerkhof, A. J. F. M., Molenberghs, G., and Van Audenhove, C. (2014). Attitudes and stigma in relation to help-seeking intentions for psychological problems in low and high suicide rate regions. *Social psychiatry and psychiatric epidemiology*, *49*(2), 231-239.

Rickwood, D. J., and Braithwaite, V. A. (1994). Social-psychological factors affecting help-seeking for emotional problems. *Social science and medicine*,*39*(4), 563-572.

Rieck, T., Jackson, A., Martin, S. B., Petrie, T., and Greenleaf, C. (2013). Health-related fitness, body mass index, and risk of depression among adolescents.*Medicine and science in sports and exercise*, *45*(6), 1083-1088.

Rigby, K. (2000). Effects of peer victimization in schools and perceived social support on adolescent well-being. *Journal of adolescence*, *23*(1), 57-68.

Roberts, C. (2007). Mixing modes of data collection in surveys: A methodological review.

Roose, G. A., and John, A. M. (2003). A focus group investigation into young children's understanding of mental health and their views on appropriate services for their age group. *Child: care, health and development*, *29*(6), 545-550.

Rosenfield, S. (1980). Sex differences in depression; do women always have higher rates? *Journal of Health and Social Behavior*, 33-42.

Rosenthal, R. (1994). Parametric measures of effect size. *The handbook of research synthesis*, 231-244.

Roth, K., and Roth, J. (1990). The System of Socialist holidays and Rituals in bulgaria. *Ethnologia Europaea*, *20*(2), 107-120.

Roza, S. J., Hofstra, M. B., van der Ende, J., and Verhulst, F. C. (2014). Stable prediction of mood and anxiety disorders based on behavioral and emotional problems in childhood: a 14-year follow-up during childhood, adolescence, and young adulthood. *American Journal of Psychiatry.*

Ruble, D. N., Greulich, F., Pomerantz, E. M., and Gochberg, B. (1993). The role of gender-related processes in the development of sex differences in self-evaluation and depression. *Journal of Affective Disorders*, *29*(2), 97-128.

Safren, S. A., Gershuny, B. S., Marzol, P., Otto, M. W., and Pollack, M. H. (2002). History of childhood abuse in panic disorder, social phobia, and generalized anxiety disorder. *The Journal of nervous and mental disease*, *190*(7), 453-456.

Sale, J. E., Lohfeld, L. H., and Brazil, K. (2002). Revisiting the quantitative-qualitative debate: Implications for mixed-methods research. *Quality and quantity*, *36*(1), 43-53.

Sarason, I. G., Levine, H. M., Basham, R. B., and Sarason, B. R. (1983). Assessing social support: the social support questionnaire. *Journal of personality and social psychology*, *44*(1), 127.

Schneier, F. R., Johnson, J., Hornig, C. D., Liebowitz, M. R., and Weissman, M. M. (1992). Social phobia: comorbidity and morbidity in an epidemiologic sample. *Archives of General Psychiatry*, *49*(4), 282-288.

Schonert-Reichl, K. A., and Muller, J. R. (1996). Correlates of help-seeking in adolescence. *Journal of Youth and Adolescence*, *25*(6), 705-731.

Schumacker, R. E., and Lomax, R. G. A Beginner's Guide to Structural Equation Modeling, Lawrence Erlbaum Associates, Inc., Mahwah, NJ, 1996.

Schwarzer, R., and Knoll, N. (2003). Positive coping: Mastering demands and searching for meaning. *Positive psychological assessment: A handbook of models and measures*, 393-409.

Schwarzer, R., and Leppin, A. (1991). Social support and health: A theoretical and empirical overview. *Journal of social and personal relationships*, *8*(1), 99-127.

Sen, B. (2004). Adolescent propensity for depressed mood and help seeking: race and gender differences. *Journal of Mental Health Policy and Economics*, *7*(3), 133-145.

Shochet, I. M., Dadds, M. R., Holland, D., Whitefield, K., Harnett, P. H., and Osgarby, S. M. (2001). The efficacy of a universal school-based program to prevent adolescent depression. *Journal of clinical child psychology*, *30*(3), 303-315.

Singelis, T. M. (1994). The measurement of independent and interdependent self-construals. *Personality and Social Psychology Bulletin*,*20*(5), 580-591.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9-27.

Smith, J. A. (2011). Evaluating the contribution of interpretative phenomenological analysis. *Health psychology review*, *5*(1), 9-27.

Smith, J. P., Tran, G. Q., and Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men and Masculinity*, *9*(3), 179.

Smith, J., Flowers, P. and Larkin, M. (2009). Interpretive phenomenological analysis: Theory, method, and research. London: Sage.

Spector, P. E., Cooper, C. L., Sanchez, J. I., O'Driscoll, M., Sparks, K., Bernin, P., ... and Yu, S. (2002). Locus of control and well-being at work: How generalizable are western findings?. *Academy of Management Journal*,*45*(2), 453-466.

Spence, S. and Essau, C. (2008) Psychometric properties of The Spence-Essau anxiety scale for adults. (*Unpublished)*

Spence, S. H. (1998). A measure of anxiety symptoms among children.*Behaviour research and therapy*, *36*(5), 545-566.

Spence, S. H., Barrett, P. M., and Turner, C. M. (2003). Psychometric properties of the Spence Children's Anxiety Scale with young adolescents. *Journal of anxiety disorders*, *17*(6), 605-625.

Spence, S. H., Barrett, P. M., and Turner, C. M. (2003). Psychometric properties of the Spence Children's Anxiety Scale with young adolescents. *Journal of anxiety disorders*, *17*(6), 605-625.

Stangor, C. (2004). *Research methods for the behavioural sciences* (2nd ed). Boston: Houghton Mifflin Company.

Steinberg, L., and Morris, A. S. (2001). Adolescent development. *Journal of Cognitive Education and Psychology*, *2*(1), 55-87.

Su, L., Wang, K., Fan, F., Su, Y., and Gao, X. (2008). Reliability and validity of the screen for child anxiety related emotional disorders (SCARED) in Chinese children. *Journal of Anxiety Disorders*, *22*(4), 612-621.

Summerfield, D. (2006). Depression: epidemic or pseudo-epidemic?.*Journal of the Royal Society of Medicine*, *99*(3), 161-162.

Swami, V. (2012). Mental health literacy of depression: gender differences and attitudinal antecedents in a representative British sample.

Thom, D. H., Hall, M. A., and Pawlson, L. G. (2004). Measuring patients' trust in physicians when assessing quality of care. *Health affairs*, *23*(4), 124-132.

Tillich, P. (1952). Anxiety, religion, and medicine. *Pastoral Psychology*, *3*(9), 11-17.

Townsend, C., Whiteford, H., Baingana, F., Gulbinat, W., Jenkins, R., Baba, A., ... and Parameshvara Deva, M. (2004). The mental health policy template: domains and elements for mental health policy formulation. *International Review of Psychiatry*, *16*(1-2), 18-23.

Triandis, H. C. (1995). *Individualism and collectivism*. Westview press.

Trompenaars, F., and Hampden-Turner, C. (1998). *Riding the waves of culture*(p. 162). New York: McGraw-Hill.

Twenge, J. M., and Im, C. (2007). Changes in the need for social approval, 1958–2001. *Journal of Research in Personality*, *41*(1), 171-189.

Uchida, Y., Kitayama, S., Mesquita, B., Reyes, J. A. S., and Morling, B. (2008). Is perceived emotional support beneficial? Well-being and health in independent and interdependent cultures. *Personality and Social Psychology Bulletin*, *34*(6), 741-754.

Van der Does, A. W., Antony, M. M., Ehlers, A., and Barsky, A. J. (2000). Heartbeat perception in panic disorder: a reanalysis. *Behaviour research and therapy*, *38*(1), 47-62.

Van Voorhees, B. W., Fogel, J., Houston, T. K., Cooper, L. A., Wang, N. Y., and Ford, D. E. (2005). Beliefs and attitudes associated with the intention to not accept the diagnosis of depression among young adults. *The Annals of Family Medicine*, *3*(1), 38-46.

Veale, D. (2003). Treatment of social phobia. *Advances in psychiatric treatment*, *9*(4), 258-264.

Wadsworth, M. E., and Compas, B. E. (2002). Coping with family conflict and economic strain: The adolescent perspective. *Journal of Research on Adolescence*, *12*(2), 243-274.

Weems, C. F., Costa, N. M., Dehon, C., and Berman, S. L. (2004). Paul Tillich's theory of existential anxiety: A preliminary conceptual and empirical examination. *Anxiety, Stress and Coping*, *17*(4), 383-399.

Weissman, M. M. (1990). Evidence for comorbidity of anxiety and depression: Family and genetic studies of children. *Comorbidity of mood and anxiety disorders*, 349-365.

Whiteside, S. P., and Brown, A. M. (2008). Exploring the utility of the Spence Children's Anxiety Scales parent-and child-report forms in a North American sample. *Journal of Anxiety Disorders*, *22*(8), 1440-1446.

Wilkinson, G., Piccinelli, M., Roberts, S., Micciolo, R., and Fry, J. (1997). Lunar cycle and consultations for anxiety and depression in general practice.*International journal of social psychiatry*, *43*(1), 29-34.

Wilson, D. K., Kliewer, W., Bayer, L., Jones, D., Welleford, A., Heiney, M., and Sica, D. A. (1999). The influence of gender and emotional versus instrumental support on cardiovascular reactivity in African-American adolescents. *Annals of Behavioral Medicine*, *21*(3), 235-243.

Wittchen, H. U., Kessler, R. C., Pfister, H., Höfler, M., and Lieb, R. (2000). Why do people with anxiety disorders become depressed? A prospective-longitudinal community study. *Acta Psychiatrica Scandinavica*, *102*(s406), 14-23.

Wren, F. J., Berg, E. A., Heiden, L. A., Kinnamon, C. J., Ohlson, L. A., Bridge, J. A., ... and Bernal, M. P. (2007). Childhood anxiety in a diverse primary care population: parent-child reports, ethnicity and SCARED factor structure.*Journal of the American Academy of Child and Adolescent Psychiatry*, *46*(3), 332-340.

Wright, A., Jorm, A. F., and Mackinnon, A. J. (2012). Labels used by young people to describe mental disorders: which ones predict effective help-seeking choices?. *Social psychiatry and psychiatric epidemiology*, *47*(6), 917-926.

Yang, L. H., Anglin, D. M., Wonpat-Borja, A. J., Opler, M. G., Greenspoon, M., and Corcoran, C. M. (2014). Public stigma associated with psychosis risk syndrome in a college population: implications for peer intervention.*Psychiatric Services*.

Yap, M. B. H., and Jorm, A. F. (2012). Young people's mental health first aid intentions and beliefs prospectively predict their actions: Findings from an Australian National Survey of Youth. *Psychiatry research*, *196*(2), 315-319.

Yap, M. B. H., Reavley, N. J., and Jorm, A. F. (2012b). Young people's beliefs about the harmfulness of alcohol, cannabis and tobacco for mental disorders: findings from two Australian national youth surveys. *Addiction,107*(4), 838-847.

Yap, M. B., Reavley, N. J., and Jorm, A. F. (2012a). Associations between awareness of beyondblue and mental health literacy in Australian youth: Results from a national survey. *Australian and New Zealand Journal of Psychiatry*, *46*(6), 541-552.

Zwolinski, J. (2014). Does inclusion after ostracism influence the persistence of affective distress?. *Group Dynamics: Theory, Research, and Practice,18*(4), 282..